

**U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration**

Advisory Committee for Women's Services (ACWS)

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Conference Room 5E49
5600 Fishers Lane
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Committee Members Present:

Nadine Benton, DFO
Mary Fleming, Chair
Anita Fineday
Shelly F. Greenfield
Hendree Jones
Dan Lustig
Karen Mooney
Sarah Nerad
Jeannette Pai-Espinosa [on telephone]
Carole Warshaw
Rosalind Wiseman

Other Participants:

Sharon Amatetti
Tom Coderre
Kathy Davis
Kana Enomoto, SAMHSA Acting Administrator
Kristie Golden
Irene Goldstein
Cynthia Kemp
Iris Mabry-Hernandez
Peggie L. Rice
Josh Shapiro
Deb Warner [on telephone]

PROCEEDINGS

Agenda Item: Call to Order

MS. NADINE BENTON: Good afternoon, and welcome, ACWS members and guests. This meeting is now called to order.

I do have a few housekeeping items. Sarah, who is our recorder for the day, would appreciate it if you would not cover your microphones. She needs to be able to hear every word that is said for recording purposes.

And now I will turn the meeting over to our chair, Mary Fleming.

Agenda Item: Welcome Members and Roll Call

MS. MARY FLEMING: Welcome, everybody. I'm excited to be here at my first meeting of the Advisory Committee for Women's Services. I know that you all have been meeting and know one another fairly well, but I would appreciate an opportunity to hear a little bit about you all and your particular interest in this committee and what you hope to see us address in the next several meetings.

We'll talk a little bit more about that at the -- specifically at the end of the day. I thought it would be useful if I also shared a little bit with you about my background, just I think you -- you reflect who you are when you participate in these meetings.

So I -- some of you may have seen me. I'm relatively new to Federal Government. I came to SAMHSA as the Director of the Office of Policy, Planning, and Innovation. And I served in that position for about 18 months. Prior to that, I've spent my career in community behavioral health. I've worked at the State level. I've worked at the community level, have done a lot of work in system transformation in mental health and substance abuse treatment.

I am -- I also worked for a managed care company. I was the founding CEO and CEO for 15 years of a company that provided and still provides oversight of managed care initiatives on the Medicaid side. Also have done a lot of work in sort of large project management for county behavioral health systems that involve implementing evidence-based practices, closing State hospitals, have done a fair amount of work in building data warehouses.

My background is in research and evaluations. I'm sort of a quantitative person by training, although have never really done research. But I love data, and I loved how you use data to inform policy, and that's where my -- my interest lies.

I came to SAMHSA in lieu of retiring, and I was sort of thinking about retirement. And Pam Hyde had asked me to consider coming, and I did. After I came here, I encountered some fairly significant health problems. And as a result, I asked to move into a new position at SAMHSA and now serve -- you know, be the chief of the National Policy Liaison Branch. And then Kana asked me to step in and fill in for her as Associate Administrator for Women's Services and take -- take over the committee management for this group, which I was thrilled to do.

I am also the mother of a son who is a heroin addict and is in recovery. So I bring that to the table also. And as much as I like to think that that doesn't cover how I approach my work, I've learned over the past 3 or 4 years, it covers it -- it touches it more than I had realized.

So that, in a nutshell, is who I am. I'm a fairly casual person. I like conversation and dialogue, and I really plan on, if you will indulge me, using this meeting to really learn about the issues of importance to you. I've reached out to a couple of you so far. Over the course between now and the next meeting, I hope to really have much more individual conversations with you in between.

So I'm delighted to be here and look forward to the day. And hopefully, you'll bear with me as I work through my first meeting. So I appreciate your patience in advance.

I'm going to -- after we go around, there are some sort of some highlights of some personnel changes going on at SAMHSA that I'd like to talk to you about and do a very highlight of the budget. If we don't get to that, Peggie Rice, who is one of our personnel changes I'm going to talk about, is going to do a little bit more detailed presentation on the budget as part of her legislative affairs update. Peggie is relatively new and is in the branch that I manage, as our Director of Legislative Affairs.

So if you all wouldn't mind going around and doing that, I'd appreciate it. And I'm going to ask the operator if you can hear me? But maybe the operator can't. We have -- I tend to start out loud and end softly. So I want to think of everybody. We have new -- this is all new AV equipment for us. So please speak up and into the phone. So we're testing all this out.

So do you want to start, Karen?

MS. KAREN MOONEY: Okay. Sure. Yeah, my name is Karen Mooney. I'm the manager of women's substance use disorder programs for the State of Colorado, for the Department of Human Services Office of Behavioral Health. I have to always have lots and lots of words in the title, you know? But I'm here actually representing the Women's Services Network, which is a component group of the National Association of State Alcohol and Drug Abuse Directors. I'm the

president of that organization right now, and I'm here basically to represent the perspective of that group and of the States providing services to women.

MS. MARY FLEMING: I talk to Rob about your group a lot. So --

MS. KAREN MOONEY: Yeah. Great.

DR. DAN LUSTIG: My name is Dan Lustig. I'm the vice president of clinical services at Haymarket Center in Chicago. We are about a 450-bed residential complex, representing both mental health and addictions treatment. We see about 16,000 clients a year come through our system. About 55 percent of them are women and women and children. We have over 30 programs in 4 locations, including onsite daycare, onsite prenatal services and primary care issues.

And one of the things that I like as part of this committee is continuing to explore the gaps in services for women. We've gone through two SAMHSA grants for pregnant and postpartum women. And clearly, in our State of Illinois that currently does not have a budget -- I'm going to keep saying that throughout the day -- that there are services that need to be maintained at all costs because a lot of the women that access services at my agency, it's their first attempt at either getting addictions treatment, prenatal care, or mental health services.

So that is it, I think.

MS. SARAH NERAD: Good morning, you all. I'm Sarah Nerad. I think this is my first like in-person meeting for ACWS. I've been at the national one before. But I think most importantly, I am a young woman that's in recovery from drug and alcohol addiction. So I guess that's why I'm here, what I represent.

I work in higher ed. I run Ohio State's Collegiate Recovery Community. So I work with college students that are just like me, and then I work with our higher education center. So we help schools across the country do alcohol and drug prevention, intervention, treatment, and recovery work.

And then in all my free time, I do stuff with youth recovery advocacy and some different pilot programs in Columbus, Ohio. So I'm really excited to be here and get to know more of you all in person.

DR. CAROLE WARSHAW: Hi. I'm Carole Warshaw. I'm the director of the National Center on Domestic Violence, Trauma, and Mental Health. And we spoke, and we're a federally funded sort of HHS Administration of Children and Families; Children, Youth, and Families; Family Violence Prevention and Services program. And we're one of a group of special issue resources centers that provide training and technical assistance on capacity building, policy, research, and public awareness on domestic -- through the domestic violence field and our center to the mental health and substance abuse fields, that

intersection, and trauma.

MS. PEGGIE L. RICE: I'm Peggie Rice, the Leg. Director, and nice to meet your acquaintance. I started my career out on the Hill, actually in the office of Patrick Kennedy and went on to work for Senate Budget Committee Chairman Kent Conrad in the Senate and then worked in advocacy in aging issues. And that's how I came to HHS, and I worked at the department in legislative affairs -- this is a very quick overview -- 15 years.

And through my work at HHS, I began to work on SAMHSA issues, and that's how I came to SAMHSA.

MS. IRENE GOLDSTEIN: I'm Irene Goldstein. I'm the writer for this meeting.

MS. ANITA FINEDAY: Good morning. My name is Anita Fineday, and I am the managing director of the Indian Child Welfare Program for Casey Family Programs in Seattle, Washington. And gosh, I don't remember how long I've been on this committee. I think more than a year. I've been here, I think, a couple of times, three times -- maybe four.

And this is our first time in this new building, right? I didn't miss anything, did I?

[Laughter.]

MS. MARY FLEMING: No, we've been -- our office has been here I think 2 1/2 or 3 weeks. So we just moved.

MS. ANITA FINEDAY: And so I work with -- on behalf of Casey Family Programs, we work with tribes from a child welfare perspective, families and children, trying to improve outcomes for Indian families and children.

MS. ROSALIND WISEMAN: I'm Rosalind Wiseman. I feel sort of like the outlier here because I'm more in the education world.

DR. DAN LUSTIG: Rosalind, there is no one more of an outlier than me.

[Laughter.]

MS. ROSALIND WISEMAN: Oh. But so I -- and I actually left, I'm a native Washingtonian and then moved to Colorado, like many east coast people do. And even though I've taught for 20 years in all different kinds of schools, moving - - it's been interesting to be part of a State in a different way.

So I work with children on everything to do with the mess of their social lives and the consequences and manifestations of that. So from consent issues that are connected to drug and alcohol on college campuses and high schools and

middle schools to understanding sexuality in girls and boys and technology and how they're understanding that and how we don't apologize it, how we reach out to them instead of shaming them or making them -- just having them tune out.

I work on all the different issues young people are interacting with that makes -- that make adults often very anxious. And so I come at these issues from -- from maybe like a side door. But I'm in -- I still, even though I'm on a national -- national level, I still am in schools quite often.

And in particular, one of the things that I'm thinking for me that's interesting around these issues about young people and the services and if they trust adults to access any kind of services with health or mental health or anything like that is that we work with this with disengagement in schools. And in particular, I've been working in Colorado with how we got the Hispanic community, the students to feel that they are a part of the public school system in Colorado.

And that's been -- and just their lack of wanting to trust adults in general with -- and no matter who you are, but particularly with that group of people. So it's something that I see sort of lots of segues and connections with what you all are here today -- what you all do that's more obviously connected to mental health and those issues and the stuff that I work on that looks more like education and engagement in school and their experiences at school.

DR. HENDREE JONES: I'm Hendree Jones. I'm at the University of North Carolina in Chapel Hill. I'm a psychologist, and I've done a lot of research looking at pregnant women, postpartum women, looking at medication-assisted treatment, as well as behavioral interventions.

And then I just got back from Sri Lanka. You wanted me to say something about this. So for the last -- since 2010, I have been working with our State Department to develop interventions for children, meaning little tiny people, like 3- to 12-year-olds, who have a substance use disorder and helping to give people in Pakistan, Bangladesh, and India the tools that they need to help have conversations with children, help intervene with children and families because we don't treat children alone. So that's just in a short nutshell what I've been -- what I literally just got back from doing.

Things I've been thinking about. So my day job is overseeing the Horizons Program, which is a comprehensive care program for women of childbearing age. It's got a residential component. It has an intensive outpatient component, regular outpatient. We have childcare. We have psychiatry. It sounds like Dan's program, only we're micro because we only treat about 230 women a year, not thousands.

So what I've been thinking about is access in rural areas to care. North Carolina is the 20th State to have overdoses, opioid overdoses. And if you look at the

map, it's all in the western part of the State. And so access for rural women to care is something that is really, really challenging for us, and thinking about gaps for children in mental healthcare has been for our women and how we can better use pediatric care facilities to identify women who have substance use disorders.

So those are some of the things I've been thinking about recently.

DR. SHELLY F. GREENFIELD: Hi. I'm Shelly Greenfield. I just would say that I've very much enjoyed being part of this committee for a while, and I always learn a lot. So I'm just always fascinated. It's amazing how much everybody is doing on this group.

Sure. Speak into the -- I can't look at you and speak into the microphone at the same time. So that's my conflict.

Anyway, I am an addiction psychiatrist. I am a professor of psychiatry at Harvard Medical School, and at McLean Hospital, I wear several different hats that are related to this. I'm an investigator in alcohol and drug addiction and have been federally funded for quite a long time. And one of my major areas of focus has been on gender differences and on women and developing treatment for women.

In particular, I've spent about 12 years developing a group therapy for women with substance use disorders who also have co-occurring disorders. We're just finishing up all of the research on that, and it took longer than I expected. But it took me 4 years to transfer the research manual into a disseminatable book form, and that is going to be out as of May 1st. And I actually brought you flyers about it. So I'm hopeful that people will, in fact, use the treatment because that was the purpose of developing it.

So that's actually on the research side a pretty large part of focus for me. I also am the chair of the Gender Special Interest Group for the National Institute on Drug Abuse Clinical Trials Network, and that's -- I've been doing that for about 10 or 15 years. And that actually focuses on how our studies are gender responsive and looking at gender differences.

On the McLean side of it, in an administrative role, 2 years ago I became the first chief of the Division of Women's Mental Health, and we have about 12 -- well, 12 units roughly congregated in 3 different programs where we treat women with mental health conditions and substance use disorders, including eating disorders, trauma, and borderline personality disorder. And this division is actually trying to unify the mission across multiple people, and we've been doing a lot of, I think, work that I find quite compelling, trying to understand how to best treat those co-occurring disorders so that the women get comprehensive, whole-person care, as opposed to, you know, just being diagnostic specific.

And that's been great and challenging. We're doing a lot of things, including

webinars for family and patients that are, you know, free to the public. We are about to start a fellowship for psychiatrists in women's mental health, and we have a relationship with the Brigham & Women's Hospital, where they're doing a lot of perinatal and postpartum women's mental health as well.

So that's on the divisional side. Let me just think, and I guess the other thing I would just mention is that I just became president-elect of the American Academy of Addiction Psychiatrists, which is an organization of 1,200 addiction psychiatrists. It's one of the DATA 2000 organizations, where we work very intensively with the other DATA 2000 organizations on a whole range of things, including public education, training for providers, very interested in medication-assisted treatments and making sure that those are actually available to patients across the country.

And of course, I come from a State that has a very -- very intense problem with opioid dependence in the State and from that whole area, New England, which is very severely affected. So that's something that all of us are also very concerned about.

And on the side for women, I'm very interested in how you actually extend gender-responsive treatments to many different settings. From this group therapy, we've actually started to develop a mobile app to just do like some gender-responsive treatments for women who are in mixed-gender settings, just so that they have some access to information. So I'm very interested in how you adapt evidence-based treatments so that they can be available across multiple settings, both in the U.S. and actually globally.

So I think that's basically some of the things that I'm interested in.

MS. MARY FLEMING: Thank you. That's great.

MS. SHARON AMATETTI: I'm Sharon Amatetti, and I know most of you pretty well. And welcome, Sarah. I haven't had a chance to meet you in person before, but of course I know about your work. So it's nice to meet you, too, and to see everybody.

So I guess this is mostly for Sarah because I think most of you know that I've been working here at the Center for Substance Abuse Treatment for many years now and manage programs of technical assistance and training around women and addiction treatment and also around parents involved in child welfare because of parental substance use.

I manage a portfolio of family drug courts and have been serving as the SAMHSA women's issue coordinator, and in that role, I coordinate with the Coordinating Committee on Women's Health at HHS, and I coordinate a group of wonderful staff here at SAMHSA interested in women's issues. And like many of

you, we've been trying to keep up with what's going on with opioid-dependent pregnant women and women and also exposed babies and have been just bombarded with press inquiries and trying to organize effort around a report to Congress that we're working on on this topic and coordinating with our other HHS agencies and other Federal agencies around this issue because it's, you know, very much on everybody's radar and mind and getting a lot of attention. And we want to be involved in helping with some solutions there.

So that's what I've been doing, and I'm happy to support Mary now in her new role as Associate Administrator.

MS. MARY FLEMING: Sharon and Nadine are just terrific people to have working with you and have really been helpful in helping to get ready for the meeting today and getting the materials together. So, and thank you all for the work that you've done in terms of preparing for today.

We have a visitor for the meeting today. Would you like to introduce yourself?

MS. KATHY DAVIS: Hi, my name is Kathy Davis. I am from the University of D.C., David A. Clark School of Law. I'm taking an administrative law class, and I'm doing a presentation on SAMHSA. So I want to thank you for that.

MS. MARY FLEMING: We do have a member who is joining us about 10:00 a.m. -- will be joining us by phone at 10:00 a.m., and Brenda Smith is not able to attend.

Agenda Item: Remarks and Adoption of Minutes for the August 26, 2015, Meeting

MS. MARY FLEMING: Before I sort of do some announcements, let's deal with the minutes from the last meeting. Could I have a motion to accept the minutes?

MS. ROSALIND WISEMAN: Yes.

MS. MARY FLEMING: I'm sorry. Is there a second?

DR. HENDREE JONES: I'll second.

MS. MARY FLEMING: Any discussion or corrections to the minutes?

[No response.]

MS. MARY FLEMING: All in favor?

[Show of hands.]

MS. MARY FLEMING: Great. Thanks.

Peggie is going -- I'm not going to spend time doing anything on the budget because I want to get us back on track in terms of time. But let me just talk about a couple of personnel changes that have happened at SAMHSA or are literally happening this week.

Amy Haseltine is on detail as the Acting Principal Deputy for SAMHSA, and she is on detail from the Office of the Assistant Secretary for Financial Resources. She is filling Kana's previous role as she moved into the Acting Administrator. Amy actually will be joining Kana this afternoon when she comes in to talk with you all. So you'll have a chance to get to know Amy a little bit. She has a lot of energy and has really been very helpful to have onboard the leadership team.

Tom Coderre, who I think you all are probably familiar with, I think is already in his third role at SAMHSA. There is a lot of changes going on in terms of leadership functions, and he is working as chief of staff. He's also really working closely with Peggie in outreach to the Hill and is, again, part of the leadership team.

Kim Johnson is the new CSAT Director. This is actually her first week. And if I'm familiar with -- if I recall the way the orientation process works, this is probably her second day, and she's in the room next door at her first advisory committee meeting. Tom Hill had been the Acting Director. He's moved into a senior adviser role. So, again, some changes.

Peggie is our new Director of Legislative Affairs. You've actually been here since the end of November or mid to end of November, but this is her first round of NAC meetings. She replaces Brian Altman, who moved into a Division Director role within OPPI. So we're delighted to have Peggie onboard.

And then Daryl Kade, who was the Acting CSAT Director, she is our -- her position of record is our Chief Financial Officer or Director of the Office of Financial Resources. She moved into CSAT as the Acting Director for a period of time. She is now the Acting Director at the Center for Behavioral Health Statistics and Quality.

Pete Delany has moved to a detail to the Office of National Drug Control Policy at the White House, and Daryl, who is the sort of perfect example of the Senior Executive Service in Federal Government, has moved into CBHSQ as the Director there. So she is currently in her third position in the last 2 years but is a highly capable manager and is probably anxiously awaiting her return to the Office of Financial Resources.

But, so we've had some changes in our -- in our leadership team. So you'll see

new faces at the JNAC meeting. So I wanted you to know about those.

Any questions before we move on?

DR. CAROLE WARSHAW: Just is that written down someplace? Because we don't know all of those people. So I was trying to -- I think we all --

MS. MARY FLEMING: We will get that to you.

MR. JOSH SHAPIRO: So, Carole, just to let you guys know, in the SAMHSA staff bios, there's an organizational chart. It's as close to up to date as it could be. So for most of what she mentioned is in the chart.

DR. CAROLE WARSHAW: And I have one other question. So is it likely that Kana will stay in this position throughout this administration because they're not going to try to appoint -- do another political --

MS. MARY FLEMING: Yeah, that would be my -- that would be my expectation.

DR. CAROLE WARSHAW: Okay.

MS. MARY FLEMING: I don't think that there will be much action.

DR. CAROLE WARSHAW: I figured, but I just wanted to --

MS. MARY FLEMING: Okay. So with that, I think I'd like to turn the meeting over to Peggie Rice, who is going -- somebody is -- you could -- somebody is controlling -- who is going to both do an overview of the legislative process for you and talk a little bit about our '17 budget, which will, I think, address -- addresses many of the issues that you raised as you went around.

Agenda Item: Orientation on the Federal Legislative Process and Women and Behavioral Health

MS. PEGGIE L. RICE: It was very helpful to hear all of your backgrounds so that we can understand what your concerns are and what your perspectives are and what you're looking to hear about. But as Mary said, I'm Peggie Rice, new Leg. Director. It's a pleasure to be here.

I'm going to do the presentation, which is a legislative overview, and that's going to include -- go ahead and click forward -- an overview of the legislative process. And you should have handouts that were over here if you want to look at the PowerPoint on your -- in the paper copy.

MR. JOSH SHAPIRO: They're in your binders.

MS. PEGGIE L. RICE: Oh, okay. Great. So I'm going to do a little overview of the legislative process, which is probably review for many of you, and discuss the Senate and House committees that we work with that have jurisdiction over our work, both appropriations and authorizations committees. And then give you just a little bit of a quick overview of our '17 budget.

So this is a slide I inherited from our previous Legislative Director, Brian Altman, who has got a great sense of humor. It says, "Who remembers Schoolhouse Rock or seventh grade civics?" I don't have any videos today. I apologize. But, and this will be a little bit more than that, but -- you can click to the next slide -- in case you do want videos, what I've got here is a resource from Congress.gov that has a quick video selection for review after the presentation that will cover some of the things that we're covering today.

But what I'm going to say is basically what happens in an ideal world. And as you all know, that doesn't always -- isn't what actually happens. But this is the process as supposed to happen.

So somebody has an idea for a bill, and they present those ideas. And those ideas are introduced as legislation by an elected official in one chamber or another. The next stage after a bill is introduced is that the committees in that chamber will then look at that bill and have hearings on the issue to learn more about them, and then they will hold a markup of the bill, which is to amend the bill and vote on it.

After markup of the bill, the bill will pass in one chamber and be sent to the other, where, if it passes, it will go to conference. And then the conference committee is a selection of members from each chamber that come together to figure out the differences between the bill and come up with a conference report that has to be passed by each chamber identically before it can be signed into law by the President.

Next slide.

So that was the first bullet, and then the President can either, obviously, sign it or veto it. And the veto can be overridden by a two-thirds vote. So there's many stages before it gets to that phase, and at any of those stages, the bill can be killed. In the Senate, as you may know, any individual Senator can put a hold on a bill without really any reason, and I think it's still confidential which Senator has the hold.

So there's a lot of, you know, procedural things that can get in the way, as we all know, and it often takes many Congresses to introduce a bill and for that to have many iterations of hearings and what not before it will actually pass. So after final passage and the bill is signed, the bill becomes a Public Law, and it's on to

the implementation phase and a possible appropriation.

So that was sort of a description of authorizing legislation. That doesn't necessarily mean that the bill has the funding to be implemented. So that's where the appropriations process comes in, and that begins -- the whole process begins with the administration. First, the President submits a budget, and that takes place on the first Tuesday in February of the preceding fiscal year.

[Door creaking.]

MS. PEGGIE L. RICE: Come on in. And our budget -- come on in.

[Laughter.]

MS. PEGGIE L. RICE: Squeaky door. Our budget for fiscal '17 was just introduced on February 9th. So the budget I'm going to talk about is very new to me. But in any case, that's where the process starts for the budget, with the President's proposal, and it's really a request. It's not money that is going to happen. It is what we're asking Congress to appropriate.

So then the appropriations chairs set the 302(b) allocations, which means how much money each appropriations bill will get overall, and then what happens within those is decided later. Appropriations tax and spending measures begin in the House. They go through the same process that authorizations go through. They go through a subcommittee markup, full committee markup, a House vote, and then they have to go through the same process in the Senate and, ideally, a conference committee and then signed into law.

Oftentimes, I think we know, though, that we've had a lot of continuing resolutions, though, and things have not had regular order. So why do we have authorizations and appropriations? This is a quote from the Senate Budget Committee Chairman Michael Enzi, "Ideally, an essential premise of good government is that Congress should authorize programs and activities before it funds them."

But in reality, according to Congressional Quarterly, the Congressional Budget Office documented \$310 billion or one-quarter of all discretionary spending in 2016 whose authorizations had expired. More than half of that amount funds programs that haven't been authorized for over 10 years. And so we see there's a situation where you don't necessarily have to be authorized or reauthorized to be funded by the appropriations process, but that's ideally what they're looking for.

So the next several slides, next three slides you'll see are going to have terms that are for your reference, just helpful later on. But I'll read the first few because we were talking about these. Appropriations bill is -- bless you -- a bill that gives

legal authority to spend or obligate money from the Treasury. The Constitution forbids money from being drawn from the Treasury but in consequence of appropriations made by law.

Authorizations act is a law that establishes or continues one or more Federal agencies or programs, establishes the terms and conditions under which they operate, authorizes the enactment of appropriations, and specifies how appropriated funds are to be used. Authorizations acts sometimes provide permanent appropriations or mandatory appropriations.

And then we discussed just now the conference, which is a formal meeting between representatives of the House and Senate to reconcile differences between the two houses on provisions of a bill passed by both chambers. And then that results in a conference report.

So we can skip past these next two and go on to -- those are all for your reference later on. This is the portion where I'll discuss the committees that we work with the most and that are impacting SAMHSA's mission and authorizations. So first, we work with the Senate Appropriations Committee. The chairman of the Senate Appropriations Committee is Thad Cochran. The ranking member is Barbara Mikulski.

Our subcommittee of jurisdiction is the Labor, HHS, Education, and Related Agencies Subcommittee. And that is chaired by Roy Blunt and Ranking Member Patty Murray. The members that you see here that are listed, those are our subcommittee members.

MS. SARAH NERAD: Can I ask a question?

MS. PEGGIE L. RICE: Mm-hmm.

MS. SARAH NERAD: What does "ranking member" mean?

MS. PEGGIE L. RICE: Okay. So the chair is the majority party. So the majority party in the Senate is the Republican Party. And there is leadership from both parties for the committee. And so the ranking member would mean, basically, the equivalent of the chair for the minority party, which is the Democratic Party in this case.

So, yeah, that's a good question.

[Door creaking.]

MS. PEGGIE L. RICE: Hi, welcome. Come on in.

Our House Appropriations Committee leadership is Hal Rogers, the chair, who's

been there for quite some time. Also the majority is the Republican Party in the House. Ranking member is Nita Lowey, a Democrat from New York. You'll see their party affiliation and State next to their names.

The subcommittee that we work with is also Labor, HHS in the Appropriations House Committee, and so our chair is Tom Cole, and our ranking member is Rosa DeLauro. And the members you see here are the subcommittee members. Of course, there is a full Appropriations Committee with a much broader membership. This is just the more limited subcommittee membership who we work with. They specialize in our issue areas and are most interested and influential in what happens, but also so are the leaders of those committees.

The Senate -- so the authorizing committees are the ones that I'll discuss next. They're the ones who determine what our programs look like, and the Senate Health, Education, Labor, and Pensions Committee is our authorizing Senate committee. The chairman is Lamar Alexander. Ranking member is Patty Murray, and her name looks familiar because she was the Appropriations ranking member, and she is situated very similarly to Tom Harkin, who was there for many years as her predecessor. He was also the Appropriations and HELP Committee chairman, ranking member depending on if he was in -- if his party was in the majority or minority.

But that happens to come in handy because you're educating the same staff, and you'll see here that's the full committee membership listed there for Senate HELP.

And this is our House authorizing committee, the House Energy and Commerce Committee. The full committee is chaired by Fred Upton, and the ranking member is Frank Pallone. And the Subcommittee on Health is chaired by Joe Pitts, and the ranking member is Gene Green. And this membership is also the - this is the subcommittee that you see here.

So the next slide is just a little bit more about SAMHSA's Office of Legislation's role. SAMHSA serves as the liaison to Congress. SAMHSA's leg. office serves as a liaison to Congress. So we're sort of the point of contact for taking in inquiries and managing their responses to be timely and complete and in keeping with administration policy and accurate, obviously, with respect to the questions asked.

Our office consists of myself and one additional person who is new, Brian Payne, a great staffer. He's actually a political appointee and also new, very new. He came on 2 weeks before me.

So what we do is we -- one of the biggest roles that we play is providing Congress with technical assistance on their legislation, which means they might be thinking about drafting a bill or have already drafted a bill, and they may or

may not bring it to us and say, hey, what is the practical effect of the language as written? And can you give us some technical assistance and tell us, you know, how would this interact with the programs? Does it do what we intend for it to do?

We don't necessarily provide input on our opinions on it. What we provide is technical expertise as to our programs and whether or not the legislation, as implemented, would do what they intend for it to do. We also --

MS. MARY FLEMING: Can I just interject? I think one of the important outcomes of that is avoiding unintended consequences --

MS. PEGGIE L. RICE: Absolutely.

MS. MARY FLEMING: -- of legislation, and that's a really important role I think that Peggie and her office play because it's not understanding how everything rolls out.

MS. PEGGIE L. RICE: Right. Right. Because things are often conceptual and the agency has experts in their programs and how they operate. And I think that the Congress and their staff are really, really, really appreciative of being connected with those experts.

So we also facilitate briefings. We just had our "four corners" briefing on the budget with the Appropriations staff. Kana and --

MS. MARY FLEMING: By "four corners," you mean?

MS. PEGGIE L. RICE: Four corners, thank you. Good point, Mary. I'm using jargon. The four corners just means the bicameral, bipartisan staff for Appropriations. Bicameral means both the House and Senate, and of course, bipartisan means the Democrats and the Republicans. So that would be the Appropriations -- House and Senate Appropriations staff from both parties.

So we did those -- that briefing yesterday. It went very well, I thought, and they were really appreciative of the Acting Administrator being present. And I thought that was great.

We prepare for hearings and draft testimony. We facilitate calls, meetings. We respond to a lot of emails. We get a lot of email inquiries, mostly about programs, just factual, you know, background about what SAMHSA does. We assist with case work. Oftentimes, they may have a grantee in their district or something or somebody who applied for a grant. They want to know the status. We just do whatever we can to facilitate answering their questions in a timely manner.

We review and clear official correspondence with the Hill, set up subject matter expert briefings. I told you that. We clear policy questions with the Office of the Administrator and in general keep the Executive Leadership Team abreast of some relevant topline issues moving through Congress.

The leg. office also serves as a liaison to the department and the administration on legislative activities so that we can be coordinated in our efforts. A lot of the work we do, obviously, is with NIDA and CDC, and so to the extent that we want to do things in tandem and be communicating with Congress all on the same, you know, topics and with a complete picture, we try to do that coordinating work.

And we also, you know, use that as an opportunity to -- we review other agencies' and departments' testimonies, for instance, to say, hey, maybe SAMHSA is doing things in this space as well. If you want to mention it, you can.

We review reports to Congress and questions for the record, which is we'll usually after a hearing, we'll get a series of lots of questions that are in written format that the members want us to respond to with the written responses because you can't nearly cover everything in an actual hearing. And the -- I think we covered all the other bullet points there.

The SAMHSA budget is also another area that the legislative office obviously has an impact on. We assist specifically with the development of the legislative proposals and the Hill rollout, which I just chatted a little bit about. We started that yesterday. Actually, a week ago, we went and briefed the House staff, and then this week, we did the four corners.

But we spearhead the policy proposal development and then also communicate the budget and policy priorities to Congress and help prepare the Administrator for hearings. And it's not -- we haven't had a ton, maybe if any, appropriations hearings, SAMHSA, as a witness. But we do have one coming up this year. It might be the \$1.5 billion in our proposal, which is a good thing. But the budget that we rolled out very recently and are discussing now with the Hill, I'm going to do a little, quick overview of.

It starts with the key priorities in our budget include engaging individuals with serious mental illness in care, addressing the opioid public health crisis, and preventing suicide, and maintaining the behavioral health safety net through our block grants, primarily.

As I said, the budget was released on February 9th, and then what it included was funding for SAMHSA as part of two special initiatives -- one on opioids, \$1 billion in new mandatory funding, and mental health initiative, \$500 million in new mandatory funding, which means that would not be funded through the appropriations process, the mandatory part.

DR. CAROLE WARSHAW: That was the President's additional \$500 million that he --

MS. PEGGIE L. RICE: Yes, that's the \$500 million, but not all of which went to SAMHSA. SAMHSA's piece was a part of that, and I'll go through that in a second.

So SAMHSA's overall budget increased from \$3.7 billion to \$4.3 billion, and you can see from the chart that is a significant increase. The purple on the top on the far right is mandatory funding, and so we also did receive some discretionary increase. But for the most part, other than the mandatory, it's fairly level.

The SAMHSA component of the mental health initiative, the \$500 million, is \$230 million over 2 years in mandatory funding for new formula grants to enable all States to establish early intervention programs, supports, and services for SMI, and enabling States that already have programs to expand their efforts. So the set-aside in the block grant allowed for initial efforts, but for a small State who probably has a smaller grant and a smaller set-aside, what this proposal does is gives each State a floor of \$700,000 to create a full program. And this is, again, part of the effort to engage individuals with SMI in care.

The next one is -- SAMHSA effort in SMI is the mental health block grant set-aside. The set-aside in the fiscal '16 omnibus was increased from 5 percent to 10 percent, and this budget proposes to continue that increased set-aside at \$50 million for the block grant, and that must be used for evidence-based programs to intervene early in onset of SMI.

This budget proposes also a new set-aside for youth in the prodrome phase. This is a 10 percent set-aside in the Children's Mental Health Initiative program, not the mental health block grant. So that's separate, a different set-aside. And that's to focus on youth and young adults who are at clinical high risk for developing a first episode of psychosis, and that's based on an NIMH prodrome study.

DR. DAN LUSTIG: Is this going to be additional revenues, or is this using existing block grant dollars and just reshaping what the percentages should look like?

MS. PEGGIE L. RICE: Are you talking about the mental health block grant set-aside?

DR. DAN LUSTIG: Uh-huh.

MS. PEGGIE L. RICE: That is we are sustaining -- in fiscal '16, the omnibus gave a significant increase in the block grants, both of them, and so -- and put the 10 percent set-aside in place. And so this sustains both the increase in the

block grant and the increase in the set-aside.

So you can go to the next one.

Engaging individuals with SMI in care. Another SAMHSA effort in the budget is something we are hearing a lot about on the Hill, interest, investing in crisis systems. This is a \$10 million investment for communities to build sustainable systems to prevent and respond to behavioral health crises and ensure post crisis follow-up services. And the budget also continues the fiscal '16 investment in assisted outpatient treatment that was included in the omnibus so that communities can test the use of AOT to reduce hospitalization, homelessness, and criminal justice involvement while improving health and social outcomes. And this includes a robust evaluation of the efficacy.

So the next -- that was the mental health initiative. The administration's \$1 billion expanding access to treatment for prescription drug and heroin abuse initiative, SAMHSA's -- this is actually all of them. SAMHSA has a portion for cooperative agreements, \$920 million over 2 years. That's \$460 million in each '17 and '18.

The second investment is in HRSA, and that is workforce training. And the third is cohort monitoring and evaluation of medication-assisted treatment, and that is a SAMHSA investment. And I'll talk about those in a little more detail next.

So the State targeted response cooperative agreements, as I said, it's 2 years, \$460 million in each year, for grants to States to close the treatment gap for opioid use disorder and targeting those who want treatment by making medication-assisted treatment affordable and available, like I said, to people who want to achieve recovery. The cohort monitoring and evaluation of MAT investment is to test the effectiveness of MAT programs in employing different treatment modalities under real-world conditions. And again, this is the opioid crisis initiative supports.

The next one is medication-assisted treatment for prescription drug and opioid addiction. This increases the MAT PDOA program, doubles it in funding for grants to States to focus on communities with high rates of opioid use disorders. And this budget has a new proposal for buprenorphine-prescribing authority, and it requires authorizing legislation. But this would be for services research demonstration to test the safety and effectiveness of allowing prescribing buprenorphine by nonphysician advance practice providers.

So what that means is it's to test having nurse practitioners and physician's assistants prescribing. It does require a legislative change to implement. And because it's different in every State who can prescribe, and we wouldn't want to get into, you know, siloing specifically who that would be, the way it is written defers to the State's authority on who can prescribe.

The next one is addressing -- continues the opioid effort. Grants to prevent prescription drug and opioid overdose-related deaths, \$12 million in grants to States for purchase of naloxone and to equip first responders in high-risk communities with this drug and training on its use. That's okay.

And then the SPF-Rx program, an investment of \$10 million and the Strategic Prevention Framework is to utilize PDMPs in prevention targeting to see where hotspots might help you focus your efforts on prevention, and that is in the form of grants to States. And then the States would then use that money to invest in the communities that they feel are -- they are tracking have higher incidence of issues.

The next targeted investment is in preventing suicide, which is a priority, obviously. This would invest \$28 million in the National Strategy for -- I should say a \$28 million increase in the National Strategy for Suicide Prevention, for a total of \$30 million in fiscal '17 to support the National Strategy for Suicide Prevention and to create the Zero Suicide program, which is a comprehensive multi-setting approach to suicide prevention that will improve identification of suicide risk, follow-up, and evidence-based interventions focused specifically on preventing suicide.

And this is with a focus within health systems and among populations high at risk. One of the things that we're sharing with the Hill in our discussions is the fact that a lot of the funding in the Garrett Lee Smith program is targeted towards the younger population, but a larger portion, proportion of suicides are occurring with the older cohort. So that is something that I think there is a lot of interest in hearing about. So, and that is --

MS. MARY FLEMING: We've really not been able to move the needle on suicide and really got a misalignment of focus with regard to funding on that.

MS. PEGGIE L. RICE: Right. And we think that, obviously, Garrett Lee Smith is a great program, and we propose continuing robust efforts there and certainly are committed to that and think that it would only be enhanced by, you know, targeting where we see the evidence focusing on a need, a gap, I should say.

So the next -- the fourth priority was the maintaining the behavioral health safety net, and that's through the SAMHSA block grants. In fiscal '16, the omnibus had a significant investment in both block grants, and this budget sustains those investments. So through the community mental health services block grant, SAMHSA supports and plans to serve adults with serious mental illness and children with SED through the public mental health system.

And it proposes to maintain the 10 percent set-aside -- we talked about that earlier -- for evidence-based programs addressing the needs of individuals with early serious mental illness, including psychotic disorders. And the SABG funds

would support services not covered by commercial insurance and nonclinical activities and services that address the critical needs of State substance abuse prevention and treatment systems.

So one of the things I have highlighted from the budget that I thought would be of interest to this group would be our -- SAMHSA's budget proposal on PPW. This budget maintains the fiscal year 2016 funding level and proposes a 25 percent set-aside within the PPW demonstration to increase the number of women served by including outpatient and intensive outpatient services.

DR. DAN LUSTIG: Can you explain that a little bit more?

MS. PEGGIE L. RICE: I will preface this by saying this budget is very new to me. So beyond what you see here, I don't have a ton of detail. But I can follow up and --

DR. DAN LUSTIG: Meaning more about the 25 percent set-aside, set-aside of what?

MS. PEGGIE L. RICE: So it carves out 25 percent of the PPW funding to be allowed to be used on outpatient services.

MS. MARY FLEMING: Right now, the restriction is around women who are in residential treatment programs. So I think there is an interest in being able to expand that -- the services so that women don't necessarily have to be in residential treatment at the time. And Sharon, you can fill me in.

MS. SHARON AMATETTI: Right.

MS. MARY FLEMING: They don't have to be in residential treatment in order to partake -- to take part in services and that we could, in fact, develop a more evidence-based approach for treatment of pregnant and postpartum women outside of residential treatment. So, but we're very restricted in the current funding, right?

MS. SHARON AMATETTI: So the PPW funding really hasn't changed very much over the last 24 years or so, but the financing landscape has changed pretty significantly. And what the intention for the 25 percent set-aside would be is to allow for some flexibility in trying some other program services that would be perhaps more flexible and that the idea is to do a pilot and to continue to ensure that a comprehensive array of family-centered services are offered, but that it could possibly be in a not residential necessarily.

There was language in there about intensive outpatient with a safe housing piece. So that's something that we understand, that housing continues to be a very pressing need for women with a high level of care. So it's to look and see if

we can maybe modernize the program some to allow for women who maybe don't want to go into residential but still have very high level of need, that they could be served through this demonstration funding as well.

DR. DAN LUSTIG: And excuse me for a stupid question, but this is SAMHSA's internal budget, 25 percent set-aside? This is not a block grant?

MS. SHARON AMATETTI: So, I think there's like -- no, this is the discretionary grant.

DR. DAN LUSTIG: Okay. Thank you.

DR. CAROLE WARSHAW: I had a question about the AOT. Can you say a little more about that? So it's like a set of new demonstration projects, or how is that going to -- do you know more about that?

MS. PEGGIE L. RICE: It simply continues --

MS. SHARON AMATETTI: Where are you? What page?

[Crosstalk.]

DR. CAROLE WARSHAW: The assisted outpatient treatment.

MS. SHARON AMATETTI: What?

DR. CAROLE WARSHAW: Assisted outpatient treatment.

MS. PEGGIE L. RICE: It basically continues what the Congress appropriated in the fiscal year 2016. They appropriated \$15 million for assisted outpatient treatment, and so we propose to continue the demonstration to test -- do robust testing of the effectiveness and see what best practices might be.

MS. MARY FLEMING: And we have for 2016 a new grant program that was authorized to target communities to evaluate, implement and evaluate the effectiveness of AOT. And this simply --

MS. PEGGIE L. RICE: It's a continuation of --

MS. MARY FLEMING: It's in mental health and would expand or continue that program.

DR. CAROLE WARSHAW: I wonder -- I don't know if there's going to be more discussion of that someplace else. But that's a -- there's a lot of controversy around AOT, and so I know when Kana mentioned in the prep call that because there's a robust evaluation, there's a way to look at how is that beneficial and

how is it coercive in problematic ways because there is that push from certain people in Congress to really promote AOT. And I just didn't know where -- I mean, it's probably politically tricky, but where SAMHSA is and what the opportunities are to kind of think about the kinds of things that might be evaluated in that program.

MS. MARY FLEMING: I mean, I think that would be maybe a good topic to talk with Kana about when she is here this afternoon.

DR. CAROLE WARSHAW: Okay.

MS. MARY FLEMING: It think it would be a great one. They are in the process of designing the evaluation now.

DR. CAROLE WARSHAW: Yeah, because I have views and thoughts about that.

MS. MARY FLEMING: I know part of that is trying to look at the literature that is in -- you know, it is an evidence-based practice on our NREPP site now. So trying to look at building off of some of those evaluations and perhaps --

DR. CAROLE WARSHAW: I mean, the Cochran review showed it wasn't really --

MS. MARY FLEMING: I understand, Carole. This is, as I recall, is a -- while it's a discretionary program, it is a line item required in the budget.

DR. CAROLE WARSHAW: You're in that position, but you have the opportunity to actually look at it in a real way? So --

MS. MARY FLEMING: Yes. Yes. We will be doing that.

DR. CAROLE WARSHAW: Because we have some thoughts about really looking at coercion within that process and to really see how that -- where it happens or doesn't happen.

MS. SARAH NERAD: What is AOT?

DR. CAROLE WARSHAW: Coerced outpatient treatment.

MS. MARY FLEMING: It's assisted outpatient treatment. It's -- it's a form, I mean, it is a form of outpatient commitment to services. So it is a requirement that in lieu of being served in a more restrictive environment, which is a State hospital --

MS. SARAH NERAD: So it's more mental health?

MS. MARY FLEMING: Yes, it is mental health.

MS. SARAH NERAD: Okay. So the court mandate you to go? Who?

MS. MARY FLEMING: Yes.

MS. SARAH NERAD: Okay. I'd never heard of that before.

MS. MARY FLEMING: It's part of the court proceeding around the admitting process.

MS. SARAH NERAD: Okay. Thank you.

DR. HENDREE JONES: Can I just go back to the PPW question? So I'd like to be really concrete. So forgive me if I'm too concrete. So the idea would be that you would be putting out like a call for proposals for this, and what would it look like?

MS. SHARON AMATETTI: Well, so part of the request for applications for --

FEMALE SPEAKER: I'm sorry. I'm sorry, I didn't hear the question.

DR. HENDREE JONES: Oh, I was asking if it would be a call for proposals or request for applications or whatever.

MS. SHARON AMATETTI: And I believe it will be embedded in the PPW request for applications.

DR. HENDREE JONES: Okay, okay.

MS. SHARON AMATETTI: That that be an option to propose, and then up to 25 percent of the total funding that's allowed will be targeted --

DR. HENDREE JONES: For that.

MS. SHARON AMATETTI: -- towards those proposals.

DR. HENDREE JONES: Got it. Thank you. That's all.

DR. CAROLE WARSHAW: I had one more question. Where is the other part of the \$500 million going that's not going to SAMHSA? Do you know?

MS. PEGGIE L. RICE: I think that was the slide that I did that talked about -- no, I didn't do a slide on the others. I can follow up with you on that.

DR. CAROLE WARSHAW: Okay.

MS. MARY FLEMING: And again, Kana may have a sense of that this afternoon. We can make a couple of notes of things to ask her specifically.

MS. PEGGIE L. RICE: It's across CDC and several --

MS. MARY FLEMING: Some is going to the Indian Health Service --

MS. PEGGIE L. RICE: Some suicide prevention efforts, going to CDC. I think there is five prongs to the mental health \$500 million. But you'll see at the end of this slide show is my email address. So I encourage you to feel free to email me, and I will answer all of your questions and follow up with more information.

So one of the things that is included in this budget, but not in SAMHSA's -- but we are intimately involved with this -- is the CMS investment in mental health for the certified community behavioral health clinic demonstration, a portion of -- well, here you go. A portion considered part of the \$500 million initiative on mental health is to expand this program from the 6 States that can demonstrate the CCBHC program to add -- actually 8 States, would add 6. So to total 14.

And I think you may know there are bills in Congress to expand it to all 24 States that we've given the planning grants to. Those were awarded in October, and Mary is intimately involved with that, and she could speak a little bit more about this program.

MS. MARY FLEMING: Well, Cindy Kemp is actually going to do a presentation to the group later today.

MS. PEGGIE L. RICE: Oh, great.

MS. MARY FLEMING: So you'll hear all you wanted to know about --

MS. PEGGIE L. RICE: I'll save that. We won't be redundant. But, so this is basically what Cindy is going to talk about is something that's already under way. We awarded 24 planning grants in October, and we will have 8 States that can do the demonstration, and our budget proposal would expand it to 14. And the many legislative proposals would expand it all the way to the 24 States.

DR. DAN LUSTIG: Mary, can you maybe just -- I know there's going to be a training on this later. But you know, in my experience with looking at the CCBHCs --

FEMALE SPEAKER: Dan, can you speak louder?

DR. DAN LUSTIG: Oh, I'm sorry. I've never had that happen to me.

[Laughter.]

DR. DAN LUSTIG: People say I'm too loud. I've noticed that addiction providers have remained -- what's the word I want to use? It's very clouded on the role of the addiction community in CCBHCs. Because what is clear in the language is that there is very little chances for them to be a CCBHC. There is more of a chance of them being a direct kind of partner, so to speak.

And I -- do you know the thinking kind of behind that and --

MS. MARY FLEMING: Well, quite frankly, I believe that this really emanated out of the mental health world, and SAMHSA was given the responsibility for developing the certification criteria. So, in fact, the inclusion of substance abuse services --

FEMALE SPEAKER: Mary, can you speak up a little bit?

[Laughter.]

MS. MARY FLEMING: Are you kidding me? So the inclusion of substance abuse services is really even to the extent they are, SAMHSA has really pushed for that. So that's sort of the basis of it, that it really came out of the mental health field.

And there are -- there has been great discussion, and Cindy will talk about this, about how you can have a single point of accountability and authority, which is the CCBHC and provide sort of some core services. So there are four core services that a CCBHC has to provide itself, and that's intake and assessment, treatment planning, outpatient mental health and substance abuse services, and crisis services, unless there is an external crisis system that they can contract with.

So the -- the inclusion of substance abuse services is really limited to what Medicaid will pay for. So, for example, residential services are outside the continuum. It can be used to pay for no inpatient or residential services at all. So the community behavioral health clinics have the option of referring to or developing their DCOs, their designated collaborative organizations, arrangements to provide the required services. And in fact, they then become, for all practical purposes, part of the CCBHC.

So substance --

DR. DAN LUSTIG: So do those DCOs have the ability to be able to collect on the advanced rates?

MS. MARY FLEMING: Well, they negotiate the rate --

DR. DAN LUSTIG: With the --

MS. MARY FLEMING: -- with the CCBHC. But those services are provided -- if they're a part of the nine required services, they are provided as part of -- used in the calculation of the prospective payment system, which is the rate that they're paid. So they cannot collect the entire PPS, but they would negotiate a rate with the CCBHC.

So one of the areas where we have worked to include substance abuse is in the crisis services in particular, that this ability for people in a crisis created by a substance abuse to get services -- not quite treatment on demand, but at least to initiate withdrawal management services in some way -- is now a requirement of the crisis system, which did not exist before. But it can only be I think it's withdrawal, and I'll rely on some of the substance abuse specialists who -- correct me if I'm wrong -- it's withdrawal management level one and two, which is an outpatient service that they have to be able to make a referral to and can be included in the PPS.

Other levels of withdrawal management are either residential or inpatient. They have to have referral arrangements with but are not included in the payment structure. So it's -- this is really driven a lot by what Medicaid will pay for and not pay for. So we are promoting a more robust substance abuse involvement, but it has been tough to sort of thread that needle.

DR. DAN LUSTIG: If I could just get on a soapbox for 30 seconds?

MS. MARY FLEMING: Go for it.

[Laughter.]

MS. MARY FLEMING: But do it loudly so everybody can hear you.

DR. DAN LUSTIG: So, you know, as an experiment, Cook County Hospital in Chicago applied for the 1115 waiver early, to implement the Affordable Care Act early. And one of the things that they did in their model was pretty much what kind of CCBHC did, with a brief sentence about addictions treatment, that it was going to be managed.

The reality is because they did not sit down with addiction providers or addiction entity, it has created 2 years of a reduced access to care and increased barriers to care because when they went into this, all they did was study the mental health rules. They didn't study any of the addiction rules or levels of care under ASANC. And so it has created -- basically, it's created several paths. One, it bankrupts some addiction providers, and it reduces access to care for other -- for clients who are in great need.

And my fear is that as we continue to look at what is reimbursable by Medicaid and not looking what the addictions field has done and is doing, we're going to continue this path of dismantling the safety net system. And it's -- and I'm -- the reason why this is a concern for me is because I've spent 2 years bathing in this, and it's -- I would expect for SAMHSA to have taken a stronger lead in this model because of the addiction system literally hanging by a thread in many States.

MS. MARY FLEMING: I think it's a great point, and I would encourage you to make it again for Cindy. I think when I talk about what Medicaid will pay for, I'm drawing a fairly black and white line there in terms of residential or inpatient services versus others. Quite frankly, the prospective payment system does provide an opportunity to -- can you hear me?

Does provide an opportunity -- I feel like I'm screaming -- to include far more recovery support services and other models of treatment and providers than has existed in the past. So there is more flexibility in terms of what you can bundle into --

DR. DAN LUSTIG: I get -- I'm with you. I just want to tell you that when it hits the ground, what is happening is that those CCBHCs are applying for addiction licenses to do it themselves.

MS. MARY FLEMING: Okay.

DR. DAN LUSTIG: Without looking at what's already in existence. So this is why a very close supervision of how this is being rolled out is truly critical.

MS. MARY FLEMING: Dan, that's really very helpful. One of the things that I do is manage what's called the statewide coordination TA activities for 223, and our -- one of our areas of focus is on how various groups are being involved in the planning of this. So the fact that -- and so doing some business back with the planning grant States about how they're looking beyond their mental health provider organizations and focusing on the substance abuse providers and others is something I hear loud and clear, and we can take that back.

And I think, again, having some of that discussion this afternoon would be really helpful. Along with tomorrow, it's a good lead-on to the 223 group.

MS. KAREN MOONEY: Yeah. I'm the discussant for this afternoon's discussion on this. But I guess I heard in your sentence how they're including, and I think the question is really whether they're including.

MS. MARY FLEMING: Well, yes, you're right. You're right. And I meant that as -- yeah. One of the things that the States are struggling with, they tell us, is how to construct the process to get meaningful input because the requirements are so

broad, as they typically are, about consumer, family, provider, community, the healthcare system, how they construct it in a way that provides meaningful input. So it's not only whether they are and how they are, but are they able to use the input they get?

So, and how out of the box are they thinking about this? Many of the outcome measures in the quality measures that are required by CMS for the prospective payment system, and then there are some additional measures that SAMHSA is requiring, are related very specifically to substance abuse treatment. And so I think that that's the other way to focus States in your discussions is to say you're going to be held accountable for these outcomes, and there are four measures that they have to report on.

DR. DAN LUSTIG: I just would hope that there is a little bit more Federal influence on holding the feet to the fire because left to their own devices, the States will take what has already been built and try to modify it. And that's the problem.

I'm just saying this because I've gone through years of trying to fix this in our State, and when the house is already built, it's very challenging. And it's a huge tidal wave heading our direction.

MS. MARY FLEMING: I agree.

DR. DAN LUSTIG: Okay, I'm done.

[Laughter.]

MS. MARY FLEMING: No, no. But it's a great -- it's a great discussion, and I think we'll have more of it this afternoon. I had forgotten, Karen, that you were the reactive. I think that will be a great discussion.

Peggie, are you --

MS. PEGGIE L. RICE: I can go ahead and finish.

MS. MARY FLEMING: If you want to wrap up, and then we can finish up with some questions and go to break?

MS. PEGGIE L. RICE: Yeah. I think we're getting behind on our schedule a little bit. Sorry. So the budget proposals, we've covered all of that. And thank you, Dan, for your input. That's really helpful. I think hearing from the people in the field is really what helps make things function, and so that's great. We really love to hear that, more of it.

Anyway, so the next point was the congressional schedule. And so this is the

114th Congress. We're in the second half of it. It's called the second session. And behavioral health and legislation on mental health and opioid use are some of the few issues that appear to have bipartisan momentum in this election year. And that's evidenced by a lot of increased activity in the form of hearings and SAMHSA appearances.

On October 29th, Kana went before the Senate HELP Committee and testified on "Mental Health and Substance Use Disorders in America: Priorities, Challenges, and Opportunities." And that was a hearing series. That was the Federal panel in which we testified with HRSA and NIMH.

And in December, the Senate Committee on Indian Affairs had us come up and discuss TLOA and our progress in the implementation of the Tribal Law and Order Act. Mirtha Beadle went up and testified at that hearing. She is from the Office of Tribal Affairs and Policy. I probably got the acronym and the name wrong.

But the January 27th hearing was in the Senate Judiciary Committee, and that was also Acting Administrator Enomoto. She testified on "Attacking America's Epidemic of Heroin and Prescription Drug Abuse." And there have been lots of hearings on opioids lately, lots of activities.

And some of the activities we anticipate coming ahead -- well, on February 11th, the Judiciary Committee marked up the Comprehensive Addiction and Recovery Act and passed a manager's amendment by voice vote, which is right now in this political arena, it's hard to get a voice vote. So that shows a lot of momentum and bipartisan support for that bill. And that bill included a PPW grant program for outpatient services, and the passage of that bill in the committee and its being forwarded to the legislative calendar for the full Senate sets it up for a potential vote as early as next week.

After that markup on February 11th, a couple of bipartisan Senators held a press conference and urged the passage of Senator Shaheen's emergency supplemental bill, S. 2423, which would provide \$600 million in funding to address the opioid epidemic. And a lot of the ideas and funding in CARA and the \$600 million emergency supplemental would fund the sort of things that we are infusing funding in right now as well -- MAT PDOA and other investments, naloxone prescribing.

So next week, we anticipate more activity. On March 2nd, Kana will be testifying before the House Appropriations Subcommittee on Labor, Health and Human Services, and she will discuss the fiscal '17 budget. She is the only witness at that hearing. So it just shows the degree of interest in SAMHSA, its work addressing the issues that we care about. After maybe, you know, many years previously when we weren't always -- our issues weren't always front and center, it really seems as though that's the case now.

And on March 16th, we just learned that the HELP Committee, the Health, Education, Labor, and Pensions Committee, is going to be marking up their own authorizing legislation on various proposals that we believe will probably be a combination of the reauthorizations that were passed in the Alexander-Murray bill, as well as maybe potentially things from Senators Murphy and Cassidy's bill, which is a Senate companion to the Tim Murphy bill in the House.

That's a mental health -- in the mental health space, but they are also including substance use in that discussion. So we look forward to seeing what that bill looks like.

DR. CAROLE WARSHAW: Do you have a sense of where things are on mental health reform and what's likely to happen and where things are with the Democratic bill versus the Republican bill in the House?

MS. PEGGIE L. RICE: I cannot tell you that much, but I do know that they don't anticipate much happening after June. So they have a very compressed timeline, and this HELP Committee markup on the 16th is really like where they will probably be discussing where -- what they are going to include in a vehicle that might pass.

And so this is obviously all conjecture, and it's based on what they can agree on and some people speculated that the Supreme Court nomination might throw a wrench into things because they would not be in an agreeable mood after that discussion. But it seems like that's not necessarily putting a screeching halt on things, and they are publicly saying we are marking up something in March, mid March. So I think there is still the prospect of activity and potentially something that might pass.

So the last slide is my contact information, and I really -- I encourage you to reach out, feel free to email me any follow-up questions you have, but I will wrap it up so that --

MS. MARY FLEMING: Thank you, Peggie. I'm a little conscious of trying to get us on time and take a break.

I would encourage you, if you have more questions about this, to save them for our discussion with Kana this afternoon. I think that would be -- she will have a perspective on it to share. And the 223, I can't wait for the discussion with Cindy.

So Dr. Hernandez is -- yes, is here. So I want us to take a quick break and come back, and we'll be ready for her presentation and discussion. There is -- you all seem to have -- many of you found coffee, and the restrooms are right near where the cafeteria is. So if you want to come back in 15 minutes?

MS. PEGGIE L. RICE: I wanted to point one more thing out. This is SAMHSA's budget. This is our congressional justification, and this is available online. There is a link. I should have put it on your materials. I don't know why I didn't. But if you want to see our proposals in detail, this is where you would find them.

So Google that, and you'll find it. It'll take a long time to download, but bring it to bed.

MS. MARY FLEMING: Okay. Thank you all.

[Recessed at 10:44 a.m.]

[Reconvened at 11:07 a.m.]

Agenda Item: The U.S. Preventive Services Task Force (USPSTF) Fifth Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services for Women, including Intimate Partner Violence, Illicit Drug Use, Major Depressive Disorder, and Suicide Risk

MS. MARY FLEMING: Okay. Thank you all. Sorry, I got caught in a conversation and am late myself. I apologize.

So I want to thank Dr. Iris Mabry-Hernandez, who is with the Agency for Healthcare Research and Quality, for coming today. She's the lead Federal liaison to the U.S. Preventive Services Task Force that looked at service gaps for women, and she is liaison from AHRQ to that group.

We invited her here today to learn what gaps the report identified regarding intimate partner violence, illicit drug use, major depressive disorders, and suicide risk for women. We are hoping this committee can help SAMHSA think about how HHS can address some of these gaps.

Dr. Hernandez, do you go by Mabry-Hernandez or --

DR. IRIS MABRY-HERNANDEZ: I do go by Mabry-Hernandez. Well, professionally, yes, Mabry-Hernandez. Personally -- but you can do whatever, you know?

[Crosstalk.]

MS. MARY FLEMING: We appreciate your coming today, and Anita is going to be the discussant, a reactant to the presentation today. So thank you, and I'll turn the meeting over to you, and can you hear me? Okay.

DR. IRIS MABRY-HERNANDEZ: Okay. Can you hear me? Okay. Thank you.

Good morning. Thank you for extending an invitation for me to talk about the report to Congress. I have three areas of focus that I want to cover this morning. The first one is just kind of a "task force 101." It's the U.S. Preventive Services Task Force, but I'll be saying "task force" -- because that's a mouthful -- for the remainder of the discussion.

The second area is talking about the purpose of the annual report to Congress. And then third is just highlighting the relevant evidence gaps that was presented in the 2015 annual report to Congress.

So the Agency for Healthcare Research and Quality, or AHRQ, or A-H-R-Q, is a pretty small agency. It's about 300 folks, and our mission is to produce evidence to make healthcare safer, higher quality, more accessible, equitable, and affordable. And also to work within DHHS and other stakeholders or partners to make sure that the evidence is understood and used.

So what does that mean? I mean, you can kind of think of it as AHRQ deals with generating knowledge, synthesizing and disseminating knowledge, and implementing and using knowledge.

And the task force falls under the rubric of the synthesizing and disseminating knowledge. So let me just talk a little bit about the task force. So the purpose of the task force is to make recommendations on clinical preventive services to primary care clinicians. And that scope includes screening tests, counseling, and preventive medications.

The recommendations only address services that are offered in the primary care setting or a service that can be referred by a primary care clinician. And importantly, I want to note that these recommendations apply to adults and children with no signs or symptoms, so asymptomatic. A lot of times people, when they respond to task force recommendations, focus on people who already have symptoms, but that's not within the scope of the task force.

So the task force uses or makes the recommendations based on a very rigorous review of existing peer reviewed evidence. So they do not conduct research studies. Again, that's sometimes a common misunderstanding that the public has is that they do research. But they don't. They don't conduct the research. They review and assess the research. And specifically, they evaluate the benefits and harms of each service based on various factors such as age or sex.

Importantly, I want to note that this -- the task force is an independent panel of non-Federal experts in prevention and evidence-based medicine. Again, a common mistake that some people make, that they believe that, you know, the task force is part of the Federal Government. But they are independent and

volunteers as well.

So I'll talk a little bit more about the task force members. So as I mentioned before, they are volunteers. The task force is comprised of 16 in the panel, and they represent disciplines across primary care, such as pediatrics, internal medicine. We also have representatives from nursing, OB/GYN, and behavioral medicine.

The task force is led by a chair and two vice chairs. Members serve 4-year terms. And task force members are appointed by the AHRQ Director with input from the chair and vice chairs. And current members, you know, range -- most of them actually still are practicing clinicians, you know, within academic settings, professors, deans, medical directors.

And there is a link to the Web site where you can actually if you want to see who is on the task force and how you can check it out.

So, so one question is how is AHRQ -- people ask is how is AHRQ involved with the task force, since it's not actually a part of the HHS or the Government? And so AHRQ is mandated by Congress since 1998 to actually provide administrative, scientific, technical, and dissemination support to the task force. And that's mainly with the use of medical officers. So I'm one of the medical officers that provide support to the task force. And as a pediatrician, most of the topics that I deal with are child health topics and some maternal health topics.

Again, as I mentioned, the Director, with input from the chair and vice chairs, appoints the task force members, and I just want to reiterate that AHRQ, you know, we provide support to the task force, but they are an independent entity. They have their own separate Web site and so forth.

So now let's shift gears and talk about kind of a brief overview of the process of how do they arrive at a recommendation statement. And so how do you nominate a topic? Actually, anyone can nominate a topic for the task force via the Web site. There's the link here.

And the public can suggest a new preventive service topic, or they can recommend reconsideration of an existing topic for three reasons. One being the availability of new evidence; two, changes in the public health burden of the condition; and three, the availability of new screening tests supported by new evidence. And so the topic nominations are accepted all year round and considered by the task force at its three meetings, which occur yearly.

Okay. So once a topic is selected, then what happens? So first, the task force has a very strong relationship with our EPC, or evidence-based center. They are usually university-based researchers that work with AHRQ through a contract mechanism. And the EPC works with a smaller subgroup of the task force,

usually three or four members that are on a particular topic -- I'll call it a topic -- and they work together to create a research plan that really kind of guides the review process.

This process can take anywhere -- and that's a process of picking a topic, and then the final recommendation statement being published -- anywhere from 18 to 24 months. So it could take a while. And that's just to make things just go smoothly, as we know they always do, right? Yeah.

But, so once the research plan is developed, it is posted on the Web site for public comment for 4 weeks, and so the task force has tried to have a lot of transparency for its process. And so there are several opportunities for public comment, and so that's the first one, the posting of the draft research plan.

After 4 weeks, it's taken down. The task force goes through all the comments and then makes revisions to that draft research plan and posts the final. So once the research plan is decided, the EPC goes off to work. They come back, and then there's a draft evidence report.

From that draft evidence report, the task force, that smaller workgroup assesses the evidence, decides on what their draft recommendation statement or draft recommendation will be, and they will vote at a particular task force meeting. After that vote, the complete draft recommendation statement is posted on the Web site, along with that draft evidence report or synthesis report for public comment, and everyone is welcome to comment. It's for 4 weeks again.

After that 4-week period, the draft report and draft recommendation statement is taken down or, rather, at least the comments are reviewed. The edits are made, accordingly. There is a final vote or a ratification that the task force does on that draft recommendation statement that becomes a final recommendation statement and then is published. And they have a relationship with JAMA now. So JAMA is publishing the recommendation statements.

The task force, when they release their recommendation statements, they have a letter grade that's assigned to each statement, and here is just a -- I won't read through all of it, but the grades are based on the strength of evidence of benefits and harms. So A and B means to do it. C recommendation means that a clinician should selectively offer or provide a service based on their professional judgment and the patient preferences because there is -- you know, there is small net benefit. D, don't do.

And then there is the I statement that people just love, and that's when there is insufficient evidence to assess the balance of benefits and harms for a service. And oftentimes, or a lot of times, you know, I don't know how many of you all follow some of the recommendations when they're published in the press. But oftentimes, people will get mixed up with the I statement and the D. They think if

you say I statement, the task force is saying not to do a service, and that's not true. They're just saying we don't know. We don't know.

And they use the I statement to focus on research gaps. I mean, certainly in the other graded statements, there is a section dedicated to research gaps. But particularly with I statements, that's a call often -- or that is a call for, you know, funders and researchers to hopefully do the work to move the needle.

Now I'm going to shift and then talk a little bit about now the report to Congress. Because the report to Congress is part of that -- is used by the task force to talk about those evidence gaps that need to be filled. And so for those -- well, some of you probably already know this, but the Affordable Care Act of 2010, very interesting, you know, after that passage, task force recommendations that are As and Bs, basically, you have coverage.

And one other interesting result from the ACA was that it mandated or charged the task force with making an annual report to Congress to recommend priority areas that deserve further examination. And so there is just -- that's the 2015 Improving the Health of Women through Research. It's available on the Web site.

So I'm just going to kind of briefly reflect on some of the previous reports to Congress. So in 2011, the first annual report to Congress looked at topics such as coronary heart disease, colorectal cancer, hepatitis C, and hip dysplasia.

In 2012, it looked at chronic kidney disease, cervical cancer, prostate cancer, and also both 2011 and 2012 looked at evidence gaps related to specific populations. For example, in the 2012, they made comments about screening for chronic kidney disease in African Americans, as an example.

In 2013, there was a shift where the task force decided to have a theme, and so they chose to focus on evidence gaps related to the care of older adults. And so looked at topics such as cognitive impairment and dementia, preventing falls and fractures, and screening for physical and mental well-being of older adults.

2014, the task force also had a theme, and this was based on or looked at the care of children and adolescents. So looked at topics such as mental health conditions, substance abuse, behavior and development, and injury and child maltreatment.

So last year, 2015, the report focused on some select topics dealing -- related to women's health. And of these, I'm going to focus on the screening for intimate partner violence, illicit drug use, and mental health conditions, as well as implementing clinical preventive services. So let's start with screening for intimate partner violence.

So the gaps that the task force highlighted are these three. Evidence is needed on the use of newer screening approaches. Further research -- evidence is needed or further research is needed on the development and validation of an accepted definition or standard of abuse. And they felt that good quality randomized controlled trials focusing on both screening and interventions to prevent the abuse of elderly, vulnerable, and middle age women are needed.

And I do want to say that certainly the task force doesn't think this is an exhaustive list of research gaps, but you know, in examining the evidence and creating the recommendation statement, these were things that stood out during the review.

Next we have illicit drug use. So determining whether patients identified by screening as using illicit drugs, whether or not they would respond differently to treatment than patients who do have a drug misuse problem who seek treatment on their own. So is there a difference between those two populations? They noted the need for studies to more clearly establish the effect of treatment on social and legal problems, long-term health outcomes, and reducing deaths.

They noted the need for studies that specifically assess treatment outcomes for pregnant women. And last, thought that there is a need or a call to action for research to evaluate the accuracy and clinical usefulness of questionnaires designed to screen for illicit drug use and misuse in primary care settings.

And depression. So looking at depression, some things or items that the task force highlighted include that they noted that there is a lack of information from large-scale randomized controlled trials on screening older women in settings that are applicable to the U.S. population. There, more research is needed on the choice between psychotherapy alone and psychotherapy combined with antidepressant treatment in pregnant and postpartum women.

Studies are needed to better clarify the best timing for screening in pregnant and postpartum women. And finally, for all populations, more research is needed to identify how often clinicians should screen for depression.

So these were the main areas that they focused on in the 2015 report to Congress. Another section that they had -- oops, I'm going too fast, sorry -- was suicide risk. More research is needed on determining who is at greatest risk for suicide. There's additional research needed to evaluate currently available screening tests and to deliver -- to develop, excuse me, better methods to identify those at high risk. Research comparing the benefits of screening the entire population versus a targeted screening of, you know, high-risk groups.

They feel that studies are needed to understand the effects of treatment on people of all ages who have been identified through screening and noted that investigating ways to link clinical and community resources could help lead to

other ways of helping people at risk for suicide. So that clinical-community resource link.

Now, okay. So what you also find in the report to Congress, and they don't necessarily have this every year, but a section on implementation. Now the task force does not review the evidence base on implementation of clinical preventive services, but they did want to acknowledge the importance of implementation. And so, you know, they have the question of how can we help women receive integrated screening and support services for intimate partner violence, substance abuse, and mental health conditions?

And so these were some suggestions for areas of research for those who are interested. And so, one, they identified timely identification of women who are suffering from intimate partner violence, illicit drug use, and so on as an important first step in addressing these conditions.

Number two, effective treatment requires intensive support from a multidisciplinary team, which includes clinicians, mental health professionals, and social and public support services.

Number three, primary care clinicians need the support of the broader healthcare delivery system, community resources, and social support services.

And the last gap that they highlighted is that more evidence is needed to understand how to integrate screening and treatment for behavioral health conditions in the healthcare setting and how entities or groups can partner -- well, in a sustainable manner to support this.

So, in conclusion, I want to say that I'm really excited that you all invited me here because this is -- I mean, this is what the task force wants is for, you know, the sister agencies to look at the report to Congress and discuss it and figure out ways of, hopefully, approaching these different evidence gaps. So I'm very interested in hearing what you all's feedback about the gaps are and I guess what SAMHSA's role would be possibly, you know, in addressing those gaps.

Thank you.

MS. MARY FLEMING: Okay. Carole?

DR. CAROLE WARSHAW: Oh, was there somebody down here?

MS. MARY FLEMING: No, no, no. I was going to tell you I didn't know if you wanted to comment or you just wanted to start with questions.

DR. CAROLE WARSHAW: No, I'm not the commenter.

[Laughter.]

DR. CAROLE WARSHAW: There's an official person who's doing the discussion.

MS. SHARON AMATETTI: So, Anita, I think you're the discussant?

MS. ANITA FINEDAY: I'm the discussant.

MS. SHARON AMATETTI: Would you like to introduce the conversation?

MS. ANITA FINEDAY: Sure.

MS. SHARON AMATETTI: Thank you.

MS. ANITA FINEDAY: So I think that we -- I think that we have a lot of questions about the presentation, and there's a lot of -- oh, and there's a lot of interest. Can you hear me? About the topic. And I think we are just going to open it up for questions, and it looks like there are some, right? Carole?

[Laughter.]

DR. CAROLE WARSHAW: Well, one of the questions I have, I don't know if you were here when we introduced ourselves?

DR. IRIS MABRY-HERNANDEZ: No.

DR. CAROLE WARSHAW: Okay. So I'm the Director of the National Center on Domestic Violence, Trauma, and Mental Health, and Substance Abuse isn't in the title. So that's exactly the work that we do. And one of the issues that's come up in building evidence for intimate partner violence interventions is that there hasn't been funding for actually doing that research. And I know the PCORI just dropped intimate partner violence from the list of things that they want to fund compared research on.

So trying to think about how to promote, I know that people have been working. There was an NIH conference a few years ago on looking at research gaps around intimate partner violence. So, and with NIMH funding being so focused on biological components, it's made it harder.

So to think about how to promote a research agenda that would actually allow us to gather the evidence for doing this would be great. Because I know there's a strong interest in being able to build that evidence.

DR. IRIS MABRY-HERNANDEZ: Obviously, it's always about funding. I didn't realize that IPV or, as we refer to it, as intimate partner violence had been

dropped by PCORI. I guess I don't necessarily have a solution, but I guess I do have one question because I don't know how SAMHSA, you know, interacts with some of the institutes from NIH as far as --

DR. CAROLE WARSHAW: Setting priorities.

DR. IRIS MABRY-HERNANDEZ: Yeah. Yes, and what is the process for that? I mean, I don't -- or talking about that. I'm sure that's probably something else that you already talk about, I'm sure.

MS. SHARON AMATETTI: So there is this Coordinating Committee on Women's Health that's run by Office of Women's Health at HHS, and the research institutes are part of that coordinating committee and actually did do quite a bit of work on the violence issue a couple of years ago and had a big symposium and was trying to encourage and did encourage cross-agency collaboration on the issue. And a couple of initiatives have come out of that, and we're continuing to work with the whole committee on.

DR. SHELLY F. GREENFIELD: Research related?

MS. SHARON AMATETTI: Yeah, my colleague Mary Blake in CMHS.

FEMALE SPEAKER: Can you speak louder, please?

MS. SHARON AMATETTI: My colleague Mary Blake in CMHS has been taking the lead on that work, and there is continuing effort to look at the screening issue, screening and assessment issue around interpersonal violence in medical settings. So that work is going on, and we were glad that the task force report also brought awareness to the issue at that level.

DR. CAROLE WARSHAW: And we also have some guidance that we're just doing final editing on how to incorporate questions about mental health and substance use related coercion in health and behavioral health, mental health, and substance abuse settings. So the combination of those three and how to do that. So those should be out soon so they'll be ready to test in pilot.

DR. SHELLY F. GREENFIELD: I guess I would just say that, you know, just like any other screening, you know -- any other type of implementation of screening we use, it's complex to consider the different healthcare environments and how and who should be best trained to implement screening, how they implement screening, thank you, what they do with a positive finding, how the follow-up is. And this is not all one same thing and complex.

And it does seem to me that given the high prevalence of interpersonal violence that -- and what we know to be the mental health and substance use disorder consequences of IPV, it's a pretty large problem and gap area for women. And I

think that, you know, it's not a small matter to consider the best ways, what the best instruments are, the best ways to implement that appropriately in culturally diverse settings, and also as with any screening, you have to have a trained workforce to implement and then carry out the next steps.

And so it does seem like that's a pretty large gap area, actually, in terms of what we know and what we currently do, you know? And that's -- so I would just put that forward as a major gap area.

I also wanted to just make one other comment on a slightly different matter, which is I think the task force also put out just a month ago recommendations for depression screening in adults, including women who are pregnant and postpartum, as a Grade B recommendation, which is a pretty big thing, actually, for them to have done. And it seems to me to be consistent with the move forward to do integrated care, you know, across primary care and other medical services settings.

And again, how the implementation of that rolls forward is always a major question because we do reasonably well sometimes in testing a screening instrument, but we have yet to do very well in how we do implementation of these kinds of recommendations and how we actually research implementation of these things. So implementation science, although that's a topic that has been labeled as a need, is still very difficult to actually obtain funding for, and it does seem to me in our healthcare system, which is incredibly fragmented, that funding more actual real implementation science to demonstrate how you can actually effectively roll these things out and scale them up is really an important gap area completely in our services system and also in the research arena.

So I would just also make that comment.

DR. HENDREE JONES: I have one comment -- well, I have a number of comments, but I'll leave it to one comment, which is just to underscore something that hasn't been discussed at all, which is human trafficking.

FEMALE SPEAKER: Yes.

DR. HENDREE JONES: Because that interpersonal violence happens many times with people who are trafficked as human beings and where they get picked up often is in the emergency departments, preventive care settings. So I would just, if there's any way that that could be in some way looked at, interwoven into it, there is so -- there is emerging research on it, but it's a huge, huge gap area where it really needs to be given much greater attention.

DR. CAROLE WARSHAW: And I wanted to come back to a couple of things that you said, Shelly. But one was around the complexity of responding when people are dealing with complex sets of issues because the initial healthcare screening

was screen, you know, assess safety, make a referral, do some very brief counseling and not the kind of in-depth, complex treatment approaches and multidisciplinary approaches that you really need to have in place that just really haven't been developed and evaluated.

We did a lit review of trauma treatment in the context of ongoing intimate partner violence, and the research is very thin, particularly for people who are still in a relationship or still in danger or still dealing with the coercion associated with intimate partner violence.

And the other thing I was going to say was around the screening for depression. There is also a lot of research on intimate partner violence and its relationship to peripartum depression. And when the recommendations came out, I read through it, there was nothing about intimate partner violence. So the chance to link those two, we may put something out about that in the next couple of weeks, but that is really important because people are thinking in silos when, again, people's lives are more complex, and having to think that way is important.

DR. HENDREE JONES: And add to it the substance use disorders.

DR. CAROLE WARSHAW: Yes. Yes.

DR. HENDREE JONES: So just all three go together. And the suicide risk all go together.

DR. CAROLE WARSHAW: Yeah, all of them.

DR. KRISTIE GOLDEN: Am I permitted to comment?

MS. MARY FLEMING: Go ahead. Would you identify yourself? Then we'll decide.

[Laughter.]

DR. KRISTIE GOLDEN: I would hold my comment until later, but my plane leaves before you do public comment. My name is Kristie Golden. I'm the new hospital administrator for an academic medical center in New York called Stony Brook. And I'm just listening to everything you're talking about, and sort of a question and a comment at the same time. And you don't need to take the time to answer it.

But the Medicaid redesign States are rolling out so much in the way of depression screening in primary care -- the integration models, the SBIRT in the emergency departments, SBIRT across multiple healthcare settings. And you talk about the evidence and looking for that evidence that's out there to assess how it's working with particular populations. And because it's the Medicaid

population, there may be an opportunity to really partner with those Medicaid redesign States to capture the Medicaid claims data to be able to look at outcomes with particular populations of patients like pregnant women and so on.

So I'm just thinking that that's not on the horizon in terms of specific partnerships with the Medicaid redesign States. It's certainly worth exploring.

DR. IRIS MABRY-HERNANDEZ: Thank you.

MS. MARY FLEMING: Any other questions or comments?

DR. HENDREE JONES: I'd just underscore the idea that we're never going to change the field until the way we train physicians and nurses changes. And until we start adding substance use disorder treatment as a relapsing illness, and there is actual real hours and days devoted to it and until we start doing that with depression and suicide risk, we're never going to move the needle.

So I don't know what the Preventive Task Force can do about that, but until we start assessing competencies, until we start making it mandatory that they get real education, we're not going to change it. And hospital administrators actually have a huge opportunity to put teeth into that.

FEMALE SPEAKER: What's your name again?

DR. KRISTIE GOLDEN: It's Kristie Golden. For that exact reason that you're describing, as part of our delivery system reform process, we chose to roll out SBIRT in 11 hospitals across our county in the emergency department, as well as throughout all the primary care practices. We're in Suffolk County. So we have a population of about 1.5 million. So it's not a small county.

And involved throughout the entire State, it's a very large rollout of Medicaid redesign. So you're exactly right. It's the implementation component that you have to spend a tremendous amount of time --

DR. SHELLY F. GREENFIELD: I mean, so one of the -- I think one of the things that helps us to confront is that it takes a lot to train everybody to do SBIRT. But then once you've trained SBIRT, referral to treatment part of it is often the problem, no matter which -- which part of the health system you are in, whether you're in sort of commercially insured, whether you're in public. It doesn't matter where you are, you can roll out SBIRT, but then the referral to treatment, where is that going, and the capacity to do that.

And again, just another comment, and it speaks to something I think Dan said much earlier, which is that patients don't have one thing. So when you do SBIRT and you identify an alcohol use disorder, which is highly prevalent in population or another co-occurring drug use disorder, that usually also goes along with a

major depressive disorder or some other anxiety disorder, often another -- often a post traumatic stress disorder or some combination thereabouts.

And so when you have a divided system that's mental health over here and substance use disorders over here, the general thing is that those people just don't really get treated, and you can do the SBIRT, but then you can't put them anywhere where they can get effective treatment. And that, I think, is being confronted everywhere in the United States now, no matter where you are and no matter which part of the health system you're in. And I think that's, you know, to speak to what you said, there's both the training of the providers, but there is really actually the capacity building in the system, which actually really doesn't exist adequately in the United States at this time.

And I think every person in this room is dealing with this, is trying to manage that in some form or another, and it's very difficult. Very difficult on all of us. So I mean, I think it's a great step forward that we can train people to screen, but we can do the SBI part, and then the RT part is really tough. And that's the thing I think right now, from a capacity-building standpoint, that's really I think where we're very stuck in every State.

DR. KRISTIE GOLDEN: It's that combination. We built collaboratives around each hospital with the ambulatory providers for that exact purpose. My background is behavioral health. So that was a key to the potential success of it was me being able to make those warm handoffs. And it wasn't just a willy-nilly let's just screen them and see what happens process. Our IT system, too, was built significantly around being able to address levels of care. So it's a lot of time and effort that goes into it.

MS. MARY FLEMING: If there -- I don't want to cut the conversation short, but we're already running behind again. But this is a great conversation. So I appreciate it. And thank you so much for coming.

Dr. Kronick, who is the head of AHRQ, will be speaking at the National Advisory Committee on Friday. So we're looking forward to hearing from Dr. Kronick at that point.

DR. IRIS MABRY-HERNANDEZ: And you pointed out, I'm curious about the follow-up as far as what happens just in general. I mean, just I know the task force would be interested, but you know --

MS. SHARON AMATETTI: So you can continue -- we'll continue --

DR. IRIS MABRY-HERNANDEZ: Yes, yes.

MS. SHARON AMATETTI: -- and I'll update you and send you the report from this meeting, too. Thank you for coming.

MS. MARY FLEMING: Thank you very much.

DR. IRIS MABRY-HERNANDEZ: My pleasure.

Agenda Item: Women and Sexual Abuse and Coercion

MS. MARY FLEMING: Now is the next loaded on here already? Okay. As we sort of shuffle the chairs a little bit --

DR. CAROLE WARSHAW: Will we have control over the thing?

MR. JOSH SHAPIRO: Yeah, I'm going to give you a slide here.

MS. MARY FLEMING: The SAMHSA's Women's Coordinating Committee has asked the ACWS to talk about and provide some guidance to SAMHSA on the topic of women and sexual abuse and coercion in particular. This group seems to have a breadth of expertise and experience in that -- a breadth of expertise and experience in that area.

So we've asked Dr. Warshaw and Dr. Greenfield to share some of their ideas on the topic, and I believe Dr. Espinosa is on the phone?

MS. JEANNETTE PAI-ESPINOSA: [on telephone] Yes, I am.

MS. MARY FLEMING: Welcome. I'm sorry that I did not acknowledge you earlier. This is Mary Fleming.

MS. JEANNETTE PAI-ESPINOSA: Hi, Mary. I'm not a doctor, but thank you for the promotion.

[Laughter.]

MS. MARY FLEMING: Oh, okay. Anytime. Will participate in leading the discussion. So in the interest of time, I'm just going to turn it over to you all to start.

DR. CAROLE WARSHAW: Okay. So we're going to do this in two parts, and then, Jeannette, you're going to add comments, and it sounds like, Rosalind, you'll probably have a lot to say, too.

So when we first talked to Sharon about this, I was trying to figure out -- we originally talked about sexual coercion, and we were trying to think of like, well, what does that really mean, and how does that apply? And there are so many different ways that people talk about it. So we were going to think about what does it actually mean, and how does it fit within the continuum of sexual violence

because it doesn't exist as its own thing?

And then, you know, in putting this together and looking at all the different types of sexual coercion, I noticed this is actually pretty horrible. And that since many of us who have experienced some form of sexual coercion, if not many, to take a minute and think about how you want to engage with this material if you, you know, have an abstract way to do it or you want to disengage. But just to think about that for a minute.

So, so I'm going to just do a kind of overview of the different kinds of sexual coercion, and Shelly is going to talk about some of the actual data, because we did separately, of the impact of sexual abuse and sexual violence on women's mental health and substance use, and then some of the treatment implications. So if you just look at sexual coercion alone, it's the act of using pressure, alcohol or drugs, or force to have sexual contact with someone against their will, or persistent attempts to have sexual contact with someone who has already refused.

And this comes from Love Is Respect, which is the teen dating violence part of the National Domestic Violence Hotline, and they've really engaged with young -- youth and young adults around texts, around social media, and very different ways than the hotline originally came to be with phone calls.

And so thinking about the continuum of sexual violence, which is the commission of a sexual act without the person's consent or when you're unable to consent or refuse, and this comes from the CDC NISVS study that one in five women experience completed rape. That about 12.5 percent experience lifetime sexual coercion, and that there were higher rates, a couple of other studies that weren't part of the CDC study among sexual minority women, and that more than a quarter of women talked about lifetime unwanted sexual contact. And nearly a third talked about lifetime noncontact, unwanted sexual experience.

And we assume that these numbers are low, given the pervasiveness of sexual predation and sexual harassment in the culture, but at least there is some baseline data there. And so you're thinking about when you're talking about sexual coercion, we're talking about both either creating or exploiting differentials in power because that's how you -- the difference between mutual decision-making and any kind of sexual encounter and coercion is that there are power differentials.

So you think about the early -- the kind of in childhood sexual abuse and in trafficking of the grooming or early enticement into sexual activity through flattery or promises or that you'll be really special. You'll get special treatment. You'll be cool. You'll get attention. You'll get love. All those kinds of things. But remembering when we're talking about coercion, it's not just early engagement, it's instrumental. The goal is for the person who is coercing to get what they

want, not to engage with someone in a mutual way.

And then it kind of moves into pressure, where there is some kind of threat, like either through guilt or through obligation or like withdrawal of affection or withdrawal of their relationship or being pressured to use substances or wearing down resistance. So it's a kind of gradual increase in the level of threat and pressure.

And then coercion, where there are actual threats to gain compliance, where, you know, you won't get something that you want, or there is a threat of violence, which changes the whole context, or exploiting someone's vulnerabilities. So someone may have to barter sex for housing or for drugs or for food or for education -- or misuse of authority. So someone who's a caregiver, who is a teacher, who is a coach, a priest, all of those situations where a younger person is vulnerable to that misuse.

And then the coerced use of substances. So, and I know a lot of you are familiar with our work where people, women in abusive relationships, their partners coerce them into using and then got them to be addicted. And this also happens in the trafficking literature. And then people are forced to use sex to get drugs, whether they're coerced into prostitution or they're coerced into just doing what their partners wants, who then controls their supply.

And then force. Either through physical violence or incapacitation and inability to provide consent. So it's like a whole continuum of what we mean when we're talking about that, and part of thinking about all these different dimensions is when we're thinking about treatment and intervention, we think what is the experience of the person who has been victimized, and what are they taking in from those experiences? And what comes up for them in either not being able to trust people and access treatment or what kinds of issues they're dealing with when they're trying to recover.

So, and again, we're thinking about the continuum over the lifespan, when we're thinking about childhood sexual abuse and the kind of grooming behavior, which I'll talk about in a minute, each of these separately. The sexual exploitation and trafficking, and for those of you who are doing work in this area, there are a number of different kinds, including trans -- LGBT controlled, but I didn't put that in because it wasn't focused on women.

So when the pimp-controlled, where young women who are vulnerable are specifically targeted for recruitment and then kind of seduced into the life and then turned out and exploited sexually. The family-controlled involves incest and childhood sexual abuse, and then they are traded and bought and sold. So, again, it's for commercial exploitation, and the gang-controlled tends to be more violent, where there are threats and sexual assault right away.

But again, thinking about what people's experiences are and partly in thinking about this work, it's you're thinking about the impact of trauma, and you're also thinking about the ongoing threats and danger and coercion when someone is entering into any kind of relationship that might lead to services. And I think about teens and casual sex and intimate relationships. There is, again, the continuum of coercive tactics, and what does consent mean, which we can talk about more.

Substance-facilitated, where sometimes young women will want to use substances because it makes it easier or then they might not feel bad about doing things that they weren't quite sure they wanted to do, versus coerced substance use or pressure into using substances to meet the demands of the person who's engaged in the coercion.

There is also a lot of reproductive coercion, both in teen and in adult intimate partner violence, where there's birth control sabotage, where people are kind of almost coerced into getting pregnant so that their partner can control them more and also a lot of issues around STD and HIV and not being able to use barrier protection when there's sexual coercion.

And also sexual harassment, which we think about in terms of jobs and promotions, but for teens, it's often verbal and online sexting and through the social media. And one of the things I was reading was talking about an electronic leash, where you can really stay connected to someone and find out what they're doing. And the sexual harassment can be part of that.

And then for adult intimate partner violence, it's in an overall context of coercive control and thinking about it in the context of threats of violence and other kinds of threats. So looking at each one specifically, the grooming is when someone builds an emotional connection with a child to gain their trust, and then the perpetrators maintain control through isolation and secrecy and sometimes threats of violence.

So with childhood sexual abuse, there may be just no grooming, just sexual assault, or there may be this process. And it raises issues for people later on around complicity and whether I went along with it and then the shame and guilt around that. So there's a lot of layers in there for -- that make a difference in people's experience.

And so minors, we talked a little bit about targeting youth who look vulnerable. So there's all the issues, not just the people coming into services, but what are the conditions that actually lead to people, young people being at risk? So run-away homeless youth, kids who are in the child welfare system, who are in group homes, who are hanging out on streets or in the malls, people are targeted online.

For Native youth, it's a big issue. There was a recent article in the New York Times of kids coming from, you know, northern areas of Canada where they have no schools and resources. They come to the city, and they are much more vulnerable. They don't have connections to their families.

So, again, some of the -- you know, my colleague Chic Dabby talked about the "pimp daddy," you know, someone seducing you into thinking they're going to be your boyfriend. They're going to put you up, set you up in an apartment. They're going to buy you all these things. They'll give you things for your family who doesn't have resources.

So it's really thinking about all the layers of that, and then the entrapment where it's very hard to get out of, both through threats and threats to send videos to your family and to your colleagues and to expose you.

And this from the -- again, from Love Is Respect, looking at coercion as a continuum for teen dating violence. And I'm not going to go through all of these, but sort of the all the more subtle ways that people try to get kids to consent as dating and sexual partners, like, you know, you owe it to them or using compliments and flattery. Saying this is the way you can prove your love for me, or I'll get it someplace else. So all those kinds of things that go into the mix when we're thinking about interventions, being very aware of the kinds of things that come up for kids, or "I need it."

So just there's a lot of work going on in the world around preventing sexual coercion among teens, and thinking about how that translates into treatment settings I think would be really important. So you want to do the video?

So, again, this is again comes through thinking about how do you negotiate differences in desire and whether that's in a context of mutuality and respect, or if that's in the context of coercion and control. Yeah, this came from -- Stephanie Covington sent this to me.

[Pause.]

DR. CAROLE WARSHAW: All right. We can look at it another time, but it's really, you know, trying to -- if you offer someone a cup of tea and they don't want it, you're not going to force them to drink it. It does it in a very neutral way that makes it very clear that what consent means and why you wouldn't pressure someone to do something that they don't want to do.

DR. DAN LUSTIG: Carole, when Stephanie designed this, was this designed --

DR. CAROLE WARSHAW: Oh, she didn't design it. She found it, yeah.

DR. DAN LUSTIG: Was this designed to educate clients or educate policy?

DR. CAROLE WARSHAW: I think it's more -- I don't know who it was designed for. I think it was more general public or --

FEMALE SPEAKER: It was all over Facebook for a while.

FEMALE SPEAKER: A lot of college students.

MS. SARAH NERAD: Was it this one?

DR. CAROLE WARSHAW: You know, I'm not sure.

MS. SARAH NERAD: It says at the very end on YouTube, it gives a little description, and I didn't know who they were. It just seemed like some random people. There wasn't like the organization.

MR. JOSH SHAPIRO: I know it is in the PowerPoint --

DR. CAROLE WARSHAW: So they talk about how someone might say yes, and then they change their mind and they wouldn't make them drink it after they decided they didn't want to. After they were asleep, you weren't going to pour it down their throat. And so it was just like kind of all the kind of nuancy things that happen around consent.

MS. SARAH NERAD: They have if they wanted to yesterday, but then today they didn't want tea.

DR. CAROLE WARSHAW: You can go through it. I mean --

[Laughter.]

[Video presentation.]

DR. CAROLE WARSHAW: Okay. So then the last one is in the context of intimate partner violence, which is, you know, by definition a pattern of coercive and controlling behaviors that are designed to establish power and control through fear and intimidation. So there's a lot of layers to it.

So one is thinking about sexual coercion in the context of implicit threat, where someone knows they're going to be subjected to violence. And for a lot of women, they may be beaten up and then sexually violated. And people talk about how horrible that feels, obviously.

So, and the threats of loss. So there's lots of different kinds of potential threats around economic loss, around immigration status, around papers, about being exposed if your -- you know, your sexual orientation hasn't been disclosed. So

you think of all the things that people can do particularly around custody is a huge threat. So thinking about what consent even means or unwanted contact means in the context of potential repercussions and violence.

The other thing in the context of domestic violence to think about is that sexual coercion is a form of psychological abuse, and often sexual degradation, humiliation, all of those kinds of insults, threats, you know, about who you are compared to other people, all that ends up being part of it, which isn't necessarily part of some of the other kinds of sexual coercion.

And then there is substance-facilitated coercion that we talked about, and sometimes it's to reduce inhibition. And in the hotline survey we did, people talked about how their partners would try to pressure them to use sex so they would be -- I mean, to use drugs or alcohol so they'd be more sexually compliant. But they also combine that to undermine people's sobriety and then to have more control over them. So they're often very much linked together.

And also using substances not only just to overpower people, but as a way to justify their actions and to then blame you for using and as imply that you consented. So it's all of those kinds of things. And then using substances or alcohol to incapacitate someone and then the reproductive coercion. The birth control sabotage is one way, and coerced pregnancy termination is the other side of the coin, depending on what the priorities are of the person who is doing the abusing.

And this is just to remind us, as I mentioned earlier, that we're talking not only about the traumatic effects of all the types of sexual abuse and violence, but also the ongoing coercion and control. So that when you're working with someone, you're having to deal with all of those things and not just the physical safety, but the emotional safety and the intrusions into treatment and trying to control treatment and control access to treatment.

And also thinking about, and I think this comes up particularly -- I know, Jeannette, you'll probably talk about this more -- is the kind of social conditions that both increase risk, like the kind of legacies of historical trauma and sexual violence that place people at greater risk for being coerced in a variety of ways and the policies that support it and the kind of complex array of services and resources that are needed to support people to be free from those kinds of risks.

So if we think about implications for treatment, these are just rates of sexual abuse, child sexual abuse and adult sexual abuse among people seen in a range of mental health settings. Shelly is going to talk more about that in the substance abuse setting -- substance use disorder treatment setting.

And then just thinking about the kind of interventions for childhood sexual abuse, there are a lot of community-based initiatives or kind of multi-generational

approaches in Native communities like the Akwesasne St. Regis Mohawk tribe that's done a lot of work across generations to end abuse and violence, a lot of work around ACEs in some of the community trauma initiatives, some of which SAMHSA is supporting. The education outreach in all the systems and particularly around the courts, around custody, a lot of times custody and contested custody and intimate partner violence custody cases where the perpetrator is actually sexually abusing the kids but manages to get custody. So that kind of issue is really important.

Thinking about making sure that complex trauma treatment is available and child-parent therapy when that's appropriate. The National Girls Initiative -- Jeannette, I'm sure you'll talk about -- is doing really the cutting-edge work in this area. And with domestic minor sex trafficking, again, there are huge Federal efforts to address this and efforts in healthcare settings. The literature, the things I've seen around mental health and substance abuse treatment are not as well developed, and really there needs to be a lot of work done on how to do that, but in this nexus of a multidisciplinary and really peer-led approaches and youth-identified priorities.

The teen sexual coercion and dating violence, there's a huge amount of work being done on the prevention side by the CDC, by Love Is Respect, and Break the Cycle, campus initiatives. You were doing work in -- trying to do work in middle schools. So thinking about how to partner with those, and there's a lot of work in adolescent reproductive health settings around reproductive coercion, but they also address sexual coercion and STI and HIV risk.

And for adult intimate partner violence, again, it's incorporating into all aspects of prevention and treatment. And for all of these, it's thinking about culturally responsive, gender-responsive, trauma-informed, trauma-specific, complex trauma treatment for mental health and substance use disorders.

And in the IPV piece, it's also thinking about attending to documentation and privacy and medical records and some of the, you know, proposed loosening of HIPAA violations and who actually has access to that information, and we know it's often used by abusive partners against women in custody battles. So to be very thoughtful and mindful how documentation takes place and what kind of technology is available to segment data when it's sensitive.

So just to end, you know, when we're thinking about treatment, we're not just treating symptoms and disorders. We're thinking about the context and what was intended by the perpetrator, what was communicated, what was taken in, what kind of exploitation, what that makes you -- how you experience yourself in the face of that kind of violation.

Think about the impact of coerced compliance and the issues of complicity and self blame and about betrayal of trust and the dangers of opening your heart as

you go forward. You know, it's really that internalized experience, depending on the type of abuse and what the perpetrator's intentions were and to thinking about sources of strength and resilience and support, whether they are internal or they come from your community, your culture, or your peers or from services.

So, again, I think at the essence of what we're talking about is responses that are very deeply collaborative and respectful, and it's kind of at the heart of what we talk about culturally responsive, trauma-informed work, but that also attends to the ongoing social realities. And you know, some of the comprehensive treatment approaches really address what it means to be female, what it means to be a person, what it means to live in the world. It's like all those dimensions -- it's not just treating symptoms -- that I think really need to be layered into this.

And what we can do to counteract the experience of objectification and dehumanization in everything that we do, the processes that see girls and women as whole people in the context of their lives and what's meaningful to them. And it also means thinking about all of the social and political and economic conditions that kind of produce and perpetuate violence against women and girls and all the efforts that we see to end that.

So I wanted to end, you know, given how sometimes hard it is to take in all of that reality that we all live with and experience, this is from Love Is Respect. This is from the National Crittenton Foundation National Girls Initiative. This is from Break the Cycle. So it's just reminding us that there is a lot going on to counteract those effects, and it's often led by young women and girls. And these are just some references that you'll have. So --

DR. SHELLY F. GREENFIELD: So it is a lot to take in, and I'm going to move into sort of part two of what Carole and I talked about. And what I wanted to do is I think Carole really set the context for the whole spectrum of sexual coercion, how complex an entity it is in society. And what I wanted to do is actually talk to you a little bit about what we know traumatic experiences pose, what kind of risks that these pose in terms of mental health and substance use disorders. And then I wanted to talk to you a little bit about treatment and some of the emerging evidence about treatment and how to treat.

And so, I mean, I think that it's pretty clear to most people in the room that sexual abuse, sexual trauma, childhood adverse events all contribute to a high risk for both post traumatic stress disorder. There is a lot of literature on that. I think that's not controversial at all. But also pose very high risk for the onset of substance use disorders in the lifetime.

And just a couple of quick studies to cite that I think are important is that the ACE study really showed that if you have four or more adverse childhood events, you are seven times as likely to have an alcohol use disorder or alcohol dependence, and four and a half times as likely to have illicit drug dependence as a result of

your sexual abuse or adverse child events.

The other really, I think, major study that was done about now 16 years ago was by Kendler and colleagues, which looked at 1,400, more than 1,400 female twin pairs, and it showed a positive association of sexual abuse with many psychiatric disorders. But the strongest association was with alcohol and drug dependence. And clearly, we know that childhood adversity and sexual abuse has a well-documented association with PTSD.

So we know that if you have this -- these circumstances, if you have suffered sexual abuse, sexual coercion as a child or as an adolescent or as an emerging young adult, or even later, you actually are at risk for both PTSD and substance use disorders, and we know among patients with post traumatic stress disorder, 65 percent or so will have a substance use disorder. We also know that among patients seeking treatment for substance use disorders, 62 percent have had a history of childhood abuse, and 50 percent of those have had -- also have co-occurring PTSD.

A more recent study, which is really interesting, that looked almost, you know, more than 3,500 female twin pairs, the Missouri Adolescent Female Twin Study, it actually showed longitudinally that women who were exposed to trauma were almost twice as likely to develop alcohol dependence. But women exposed to trauma who also had PTSD were four times as likely to develop alcohol dependence. So these things are really like very -- these are highly co-occurring, highly comorbid disorders amongst people who have had these events in their lifetime.

We also did a study that showed that if you are alcohol dependent and you have a history of sexual abuse, you're more likely than a nonabused patient after treatment to relapse to alcohol in the first year following treatment and relapse more quickly than somebody else. So it actually affects your treatment prognosis, and we know that PTSD worsens substance use disorder symptoms, substance use disorders themselves worsen PTSD symptoms, and that the treatment outcomes for these co-occurring disorders are actually worse than for either of those alone.

So that presents us with, as we are seeing patients, an opportunity to do treatment, but also we want to try to do the emerging most effective treatments with patients. And historically -- and this is the part I really want to sort of drive home. Historically, there have been concerns that if you treat trauma and substance use disorders concurrently, what you would do is increase the distress and worsen the substance use disorder treatment outcomes. So, but what we have found, and I want to show you a couple of studies and --

MS. ROSALIND WISEMAN: I'm sorry, can you say that again, please, Shelly?

DR. SHELLY F. GREENFIELD: What are the concerns?

MS. ROSALIND WISEMAN: Just say that again.

DR. SHELLY F. GREENFIELD: So, historically, the concern has been that if you treated the two things together, you would actually worsen substance use disorder treatment outcome. So, in other words, the idea would be that if you're getting treatment for substance use disorder and you also were co-treating PTSD, that the person would become so distressed that their substance use would become worse.

And so, essentially, the treatment system was asking women with both to go to substance use disorder treatment but don't talk about the trauma. Get clean and sober, then go talk about the trauma. And that's been the -- so in a sequential thing, and I'll show you that in a second.

What I really want to drive home is that converging evidence actually is demonstrating that that's not correct and doesn't seem to be correct. Our system is generally geared to do this, and this is a problem to our earlier discussion about having mental health and substance use disorders separated because we often force women to bounce back and forth and not ever become really treated.

So before I kind of say that, I mean, I want to just show you the evidence because we have converging evidence that demonstrates that concurrent treatment of PTSD and substance use disorder clearly improves the outcomes for PTSD and certainly does not worsen the substance use disorder outcome and may, over the long term, as the PTSD come under control, the substance use disorder actually has a better shot at resolving.

And so, let's see, can I do that? So just historically, this is what we've done in the treatment system. We've either done sequential treatment for people with co-occurring disorders. We treat one disorder. Then we treat the other. So, traditionally, it's been you treat the substance use disorder. Then you send them for their PTSD treatment, where they don't want to talk about or deal with the substance use disorder. They just want you to be clean and sober and now treat the PTSD.

We've also done parallel treatment where we have them do some PTSD treatment over here and some substance use disorder treatment over there, and the patient is supposed to kind of integrate that. And now what we really have are emerging treatments that are really integrated treatments where they simultaneously treat both disorders concurrently.

So what I want to show you is that I just hope everybody already knows that we have wide, broad, evidence-based psychosocial treatments. I should have had CPT up there. For psychosocial treatments for trauma, we CBT, we have

prolonged exposure, EMDR, and we also have CPT, cognitive processing therapy. These are sometimes considered present focused and past focused. I won't really get into that. We have a range of psychosocial treatments for substance use disorders that have been, you know, demonstrated to be effective.

And what I want to do is highlight two integrated psychosocial treatments for co-occurring PTSD and substance use disorders and some of the evidence behind them because they actually are converging in terms of what they demonstrate. So I know most people are aware of Seeking Safety. I want to talk to you a little bit about that, and then a really newer emerging treatment, the concurrent treatment of PTSD and SUD using prolonged exposure, which is the COPE study.

So the next slides are just going to just highlight for you the evidence of both of these because I think they are very important and interesting, and it's an emerging evidence base about how to do this treatment. So Seeking Safety, I wanted to highlight, I think you know Lisa Najavits developed Seeking Safety as a short-term manualized cognitive behavioral group therapy focused on co-occurring SUD and PTSD. And Dr. Najavits feels that some of the outcomes are based on whether you do a full versus a modified program.

But I wanted to highlight through the National Institute on Drug Abuse Clinical Trials Network, the first major multisite RCT of Seeking Safety was done versus a women's health education. That involved 353 women. They did 12 group sessions over 6 weeks, and they had basically a 12-week post treatment follow-up.

Dr. Denise Hien is the -- is a wonderful colleague, a psychologist who actually was the lead investigator for this multisite RCT. And what she found was that during the intervention phase, the mean PTSD symptom scale, the report of PTSD symptoms actually declined significantly for both conditions. There was no significant change in substance use from baseline. And what she concluded from the study was that they could do integrated treatment -- this is a very large study -- for both PTSD and substance use disorder without increasing substance use in the population.

So opening -- what she calls opening Pandora's box did not produce the outcomes that everybody was fearful and worried about. And in fact, there was some evidence -- and she did a secondary analysis, a subgroup analysis. There was some evidence that there were actually substance use disorder improvements in this subgroup, especially regarding alcohol dependence, that there was a group that actually improved with regard to their alcohol use, what she calls the titrators.

So that's a CBT-oriented type of treatment that really, I think, contributes evidence to show that these things can be effectively co-treated. There is

another study that just was published, and this is Sudie Back at the Medical University of South Carolina, along with a range of colleagues, including Edna Foa, and they developed this COPE model, Concurrent Treatment of PTSD and SUD using Prolonged Exposure.

Basically, what people really said is CBT is sort of a basic present-focused, skills-based treatment. People really veered away from prolonged exposure, which prolonged exposure is actually demonstrated to be quite effective for PTSD. People worry about by exposing people to trauma, having them decondition their responses, this would be too difficult, and substance use disorders would become much worse.

So COPE is a very interesting model, and they developed it in response to the recognition of these unique needs that I just discussed. And in response to the sense that the standard of care to treat the SUD first and then the PTSD was really not working for all sorts of populations -- women, but also veterans, a whole host of people -- and that there were poor outcomes in standard treatment. And so COPE integrates two evidence-based treatments, prolonged exposure therapy for PTSD and relapse prevention for substance use disorders.

And they did a randomized controlled trial, which demonstrated, just like Seeking Safety, substantial reductions in the PTSD and no worsening of substance use disorder symptoms. So just to say COPE is 13 individual 60- to 90-minute therapy sessions. It's individual, not group. It has these components, which includes education, CBT techniques to manage cravings and high-risk thoughts, coping skills training, and then they do breathing, retraining and relaxation exercises in response to in vivo real-life exposures or imaginal exposures or both.

And what they've found is they did a randomized controlled trial of COPE plus treatment as usual, compared with treatment as usual, and the PTSD symptoms clearly improved. There was no increased severity in substance dependence in either group. Most patients did continue to use substances through the study, and again, they concluded, just like Denise Hien, that the results challenged the ideas that patients need to first be treated for the substance use, be abstinent, and then move to PTSD treatment, and that you can use prolonged exposure in this population.

So there are other studies that have showed that improvements in PTSD, if you can follow people long term, their substance use hasn't worsened, and then if their PTSD symptoms remain lowered or resolved, the substance use disorder actually then improved downstream. So it really highlights the importance of trying to treat these two together and ultimately to also improve the substance use disorder outcomes.

So just a quick summary. I think Carole demonstrated that there is this very high

prevalence in our society and worldwide, actually, of sexual abuse coercion, intimate partner violence. We know that sexual abuse, other violence, trauma, and adverse childhood events are very potent, powerful risk factors for PTSD and substance use disorders, and these two things don't inevitably, but very highly often co-occur. And each predicts worse treatment outcomes from the other.

And the challenge is to treat the disorders concurrently, not sequentially, but really in an integrated way. There are now two demonstrated treatments that have shown that you can do this and improves PTSD symptoms with "no worsening of SUD treatment symptoms" during treatment and probably some improvement down the line if the PTSD symptoms remain resolved.

But I would just add that in order to really help populations who have these co-occurring disorders, we actually really do need more investigation to really figure out the right effective combination of the components of care, the duration, the scope, the population based in the right environment culturally to identify the optimal models of how you would treat these two together. So, so that's what I want to say.

And what I did was I provided you with a bibliography so you have all of the studies I just cited, and you can go and check them all out.

COPE just came out. There is a therapist guide to COPE. It just came out from Oxford in 2015. I've provided you with the reference. And that was really, I think, a very intensely initiated, carried out, implemented study. They did a lot of in Australia. They have collaborators in the U.S. and abroad, and so I think it's a -- I think these two are very important integrated treatments for us to know about.

So that's where I'll stop.

MS. MARY FLEMING: Thank you. Jeannette?

MS. JEANNETTE PAI-ESPINOSA: Yes. I'm here. Just had to unmute myself and pick up the phone. I'm sorry to not be there with all of you in person, but such is life.

DR. CAROLE WARSHAW: We are sorry, too.

MS. JEANNETTE PAI-ESPINOSA: I really enjoyed both of your presentations and the PowerPoints. I had the chance to look at them earlier and had just a couple comments, both in terms of the ACE and then sort of the concept of coercion and a little bit on treatment. And one of the things about the ACE is, you know, I think most of you probably heard I did a presentation a while ago on our use of ACE in our agencies in 2011. We just last year released new data, and this time we had an external researcher.

And the interesting thing that we discovered that I think is really kind of applicable to this conversation just even above the ACE is that we discovered because this time in doing the ACE, we included well-being domains and different outcomes. And we saw that there was a significant difference between young women, and when I say "young women," I'm talking about really 12 to 21. So those that have scores of 4 to 7 didn't really present as being very much more stressed whether they were a 4 or a 7. But when you bumped into 8, 9, and 10, things changed dramatically.

So as we looked at that data, we saw real significant differences in prevalence, which I'll share with you, to specific ACEs, as well as in outcomes. So when we looked at the 8 to 10 group as separate from those who had a score of 4 to 7, traditionally we have said 4 or more, 5 or more, rather than breaking them down. We saw that those with a score of 8 to 10 had the same prevalence for sexual abuse, roughly speaking, as the group that was 4 to 7, but a higher prevalence of emotional neglect, physical neglect, physical abuse, and substance use disorder of caretakers was significantly higher.

And when we translated that to outcomes, we saw that the girls with a score of 8 to 10 had much more placement instability. They were higher percentages were trafficked for sex. They had more multisystem involvement -- so juvenile justice, child welfare, mental health -- and higher percentage of young moms.

So, so for us, this was kind of new. We really -- we really hadn't drilled down. You know, we had looked at individual scores. So what's 4 and above, and then what is different about having a 5 or a 6 or a 7? But we really didn't see in the early data run the significant difference between those with scores of 8 and 10 and lower than that.

We also had the opportunity to look at 109 children of younger moms, and we saw that by the time the children were 7 to 10 years old, they already had an ACE score of 5 to 6. Interesting thing was, however, that their scores at 7 to 10 were still lower than their mothers', and the prevalence for their children was different of ACEs. So much less sexual abuse than the mothers, but still very high scores.

So I thought, as I was listening to both of you talk, that the impact of sort of the generational substance use disorder and other family dysfunction really, really jumped out when we looked at girls with scores of 8 to 10. And in the well-being indicators, we looked at stress, coping, and connection. They were much less connected, much more highly stressed, and had much lower coping skills.

And so we started having conversations with this group of women who had scores of 8, 9, and 10, and we found that the women who do advocacy work for us tend to have scores 8, 9, and 10. Really, 7, 8, 9, and 10. And we actually had

some conversations with them about the term "coercion" because, you know, I think it's coming up more in the literature, and so we kind of wanted to get their take on it.

And interestingly enough, for them, what they've said back to us was you really have to understand that as children, sort of over their life span to date and the context of their lives, they really don't know a life with any safety and any sense of free will or choice or consent. So the idea for them of coercion is not -- it takes a while before they can identify coercion because for them, you know, a lot of them said, well, you know, our life is built on exploitation. Our foster parents say, you know, we're here -- you're here because we get a check.

So the idea of their value being connected to money is something that they really grow up with. And then, interestingly enough, also they said, you know, this idea of trading sex -- for safety, for food, for a place to sleep -- to them really signals for them a sense of empowerment and their ability to survive, despite the context of their lives.

And then on top of that, for those young women that were trafficked, they said, you know, you don't -- you think the trauma for us is being trafficked. The trauma for us is understanding that we were actually exploited or coerced because we think that we're doing that in our best interests because it's a better life than the life we came from.

So it really -- it's really interesting just talking to them about coercion. They are -- just have a really different perspective of when they can see that. And most of them said, you know, they were probably 18, 19 before they really saw that it's something that they could relate to.

And you know, when we asked them sort of what -- so what kind of support do you need? They said, of course, you know, we need therapy, and we need treatment. We need support with our addiction issues. But they really focused more on I think both what Shelly was kind of getting at through the different models then and what Carole was talking about, is they really -- they really need healthy relationship models. A sense of community, safe relationships. They need support to build their self esteem.

And they talk very articulately about the clinical advantages of sharing their experiences and doing advocacy work. And we've had some come to Washington, D.C., with their mental health support person and they're standing in front of this congressional briefing, and that's where they choose to reveal that they've been trafficked, whereas they have not said that in their individual or group therapy session for the last 6 months.

So, and then they talk a lot about rites of passage and how important that is, even though we think they're older and those things that they should have

experienced and that you hear a lot of people doing proms. Those things are really important to them. So, yeah, that was kind of my reaction to the presentation.

DR. DAN LUSTIG: Quick question. You know, I've got a 16-bed sexual trafficking program in Chicago. And one of the things I've struggled with probably close to 300 women who've come through the program is engaging them in the very first aspect of the program. Keeping them retained in the program has been the biggest challenge.

And so did any of the studies kind of examine how do you engage women safely? It's beyond creating a safe environment. It's beyond building trust.

MS. JEANNETTE PAI-ESPINOSA: Right.

DR. DAN LUSTIG: It's beyond -- the biggest challenge is how do we create an environment that is engaging that they're willing to bite onto at the very beginning?

MS. JEANNETTE PAI-ESPINOSA: Right, right.

DR. DAN LUSTIG: Is -- I was --

MS. JEANNETTE PAI-ESPINOSA: So that they want to leave the life.

DR. SHELLY F. GREENFIELD: How do they get to your program?

DR. DAN LUSTIG: Through the sexual trafficking hotline. So they have called the hotline.

DR. SHELLY F. GREENFIELD: They have called.

DR. DAN LUSTIG: And --

DR. SHELLY F. GREENFIELD: So they've taken the first step.

DR. DAN LUSTIG: Yes. But I mean, as you guys know, there are so many compounding variables. Many of the women I've --

MS. JEANNETTE PAI-ESPINOSA: Right.

DR. DAN LUSTIG: -- engaged with have been sexually trafficked by their husbands, family members. So you know --

MS. JEANNETTE PAI-ESPINOSA: But what age are you working -- what ages are you working with?

DR. DAN LUSTIG: The youngest is 18, and then it goes up from there.

MS. JEANNETTE PAI-ESPINOSA: And do you use other trafficking survivors?

DR. DAN LUSTIG: Absolutely. Absolutely. And again, you know, I've tried so many different ways to engage that it's just not been successful, specifically, and we're able to do some screenings to try to get the women, try to hone in on what to engage with. But it's a huge challenge.

MS. JEANNETTE PAI-ESPINOSA: It is. And you know, we have of our -- we have 26 agencies, and just under half are working with young women who have been trafficked. And I mean, kind of the consistent message there is the younger the woman, the more you have to be willing to let them leave and come back, and leave and come back.

DR. HENDREE JONES: Do they come back? Or do they just leave and not come back?

DR. DAN LUSTIG: Some. I would say --

MS. JEANNETTE PAI-ESPINOSA: They do. I mean, those that -- those that are -- have the will and are willing to sort of buy in 100 percent come back. Now they may not come back -- some come back right away. Some don't come back for a year. But generally most of them, I would say, maybe 60 percent do come back.

DR. HENDREE JONES: Hmm, what's been your experience, Dan?

DR. DAN LUSTIG: So my experience is I have far less that come back. So I would say maybe 1 percent come back.

DR. HENDREE JONES: Oh, wow.

DR. DAN LUSTIG: It could be that it takes a while because I'm now starting to see women come back.

MS. JEANNETTE PAI-ESPINOSA: Yeah.

DR. DAN LUSTIG: Who've been in there a year or two ago, but it's very, I think, frustrating from a staff perspective where you see the traumatic events of the women accessing -- you know, they've taken that first step. The minute either the drugs leave their system, they've kind of had 24 hours to readjust, the pull to leave is too big.

And one of the things that I don't want to do, some of the women have been picked up by police. Some of the women have gone to court. I don't want to

advocate that they require them to go to treatment. That's not the answer.

MS. JEANNETTE PAI-ESPINOSA: Right.

DR. DAN LUSTIG: But the fear that I have is the lifestyles that these women are going back to are so horrific --

MS. JEANNETTE PAI-ESPINOSA: Yeah. I mean, I think part of the issue and we've had to deal -- you know, provide support to our staff is, you know, as much as we perceive them to be everything you just described, you know, the power to normalize those behaviors, particularly given what they might have experienced before, is so powerful. And from my recollection of the conversations, that's what they meant when they said you have to understand it's very traumatic for us to understand that we were being exploited.

DR. DAN LUSTIG: And I get that.

MS. JEANNETTE PAI-ESPINOSA: So then we have to go through betrayal again.

DR. DAN LUSTIG: I just would -- I guess my thought is this, to me, is a serious gap in understanding, is how do we, for sake of a better word, capture that new person who has taken that step, who has actually a step to go into a healthy direction and motivate them to continue?

DR. SHELLY F. GREENFIELD: Could I -- I'm sure you do this. I'm just curious about when someone comes in, I mean, are you --

FEMALE SPEAKER: Shelly?

DR. SHELLY F. GREENFIELD: I'm sorry. When someone comes in, are you, I'm sure you are, but are you like systematically evaluating what they -- how they explain why they are coming in, like what their -- what their specific model of what the help seeking is about?

DR. DAN LUSTIG: Yes. By people who've come through the program. So by other women who have been exploited and have moved into the healing professions, they are the ones that are leading the screening.

DR. SHELLY F. GREENFIELD: But do you -- are you keeping the data about -- because I guess the two things that I would wonder about is up front when the people, when women come in, understanding what their -- you know, what exactly is their motivation at that moment in time for what they are looking for? How do they explain to themselves and to you what their problem is and what they're seeking?

Because that's one part of it, and then second would be, as they leave, I don't know if they just disappear and leave or whether they get discharged. But as they're leaving, trying to systematically collect some data about what they actually say is the reason. And because in a way what you're looking for is sort of the person's experience of the motivator for coming, and then their explanation of what the barrier that they are facing to actually staying in care is.

I mean, I would wonder about systematically evaluating it so you would have some database about that. Because then you might have an opportunity to begin to adjust how you discuss what the program does and doesn't offer and then perhaps offer some voluntary -- you know, voluntary engagement with elements of the program. You know, that would just be a first -- first thought.

DR. DAN LUSTIG: And we do do glimpses of that.

DR. SHELLY F. GREENFIELD: Yeah, this is a very interesting problem that you -- it's a very interesting problem that you're -- you know, you're describing, and I think I'm sure for most people who are treatment providers or running a program, it's replicated in different ways in different programs. It's not unique to your --

DR. DAN LUSTIG: Right. Right, right, right.

DR. SHELLY F. GREENFIELD: I mean, it's -- I think this is something that everybody confronts and probably with particular population you're working with that have been, you know, involved in human sex trafficking. I mean, it's even a subgroup of the broader group who have had both.

MS. JEANNETTE PAI-ESPINOSA: Right.

DR. SHELLY F. GREENFIELD: And very many barriers, you know, to their engaging. But anyway, that's just a first thought.

DR. DAN LUSTIG: Thank you.

DR. SHELLY F. GREENFIELD: I would like to talk to you about it.

MS. MARY FLEMING: Excuse me. I hate to cut off the conversation yet again. But this has just been terrific. It's been very interesting. We might talk a little bit at the end of the day if there is some follow-up or continuation that we want to do at the next meeting, but I do want to break for lunch. I know Cindy is coming, and then Kana and Amy will be here, and I know both of them are running on a fairly tight timeframe. So we'll have to try to get back on track.

So if we could take a break for lunch and reconvene at 1:15 p.m., which is when I think Cindy Kemp will be here to start, that would be terrific. The cafeteria is out there. It's quick. They have a wide variety of pretty much whatever you want.

So --

MS. JEANNETTE PAI-ESPINOSA: Okay. There's a lot of noise. What time are you coming back?

MS. MARY FLEMING: 1:15 p.m.

MS. JEANNETTE PAI-ESPINOSA: 1:15 p.m. Okay.

MS. MARY FLEMING: Yes.

DR. CAROLE WARSHAW: Thanks, Jeannette.

[Recessed at 12:40 p.m.]

[Reconvened at 1:23 p.m.]

Agenda Item: Certified Community Behavioral Health Clinics

MS. MARY FLEMING: My new best friend at SAMHSA, Cindy is chief of the Community Support Program Branch in CMHS and among many of the responsibilities is agency lead on Section 223, the Excellence in Community Behavioral Health Center Act, which, as you all probably know, is one of the highest priorities of the agency and the administration at this point in time.

So we've asked Cindy to do a presentation. It also will be one of the breakout groups tomorrow during the joint meeting. And after Kana leaves, we're going to talk a little bit about the breakout groups and what kinds of questions that you'll be asked to think about for those groups. Cindy will be facilitating that group also.

So I did forewarn her that there were already questions coming up, and she is highly capable of answering them all. So, Cindy, I want to turn it over to you. We have a request to speak loudly. That is not really an issue for you.

And I never thought it was an issue for me, but apparently it is. So, Cindy, take it away.

MS. CYNTHIA KEMP: Okay. All right. Well, first of all, thank you for having me. I'm really pleased to be here. I go home at night, and my husband says, "What did you do today?" And I said, "Oh, I did this on 223, and I did this on 223." And he says, "Oh, my gosh. Aren't you tired of talking about 223?" And the truth is, no, I'm not tired of talking about 223.

And the reason I'm not is because it is an incredibly exciting opportunity for us to do something different with our behavioral health services nationwide. And when I say different, I mean improved, better, accessible, expanded. It's an incredible opportunity.

So what I'm here to do today is to talk with you about it. I'm going to give you a good foundation for what this demonstration is all about, and then we'll talk about women and girls and how they may fit into this demonstration. And then I'm happy to answer any questions.

So my -- but my first question to you is how many of you know about the Protecting Access to Medicare Act Section 223?

[Show of hands.]

MS. CYNTHIA KEMP: Okay. A little bit. Okay, okay. So that's good.

All right. So where are we? That's me. All right. So starting in square one, in March 2014, Congress passed the Protecting Access to Medicare Act of 2014. It is a huge act, and it has all these different sections in it. And Section 223 is on improving community behavioral health services.

So it's interesting because I've been with SAMHSA for about a year and a half. I was with SAMHSA for 3 weeks when Pam Hyde, who was the Administrator, called me into her office. We had a nice little chat, and at the end of the chat, she said, "I have an interesting demonstration project that I'd like you to lead."

And first of all, you don't say no to Pam Hyde. So I said, "That sounds great. I'm happy to do that." And it's been an incredible amount of work, but I wouldn't have traded it for anything because it is -- it is an opportunity to really do something different and to make some significant changes nationwide. I really see it as a game changer.

And here is what I tell people. It has an opportunity to improve the behavioral health of the citizens in our Nation by providing community-based mental health and substance use disorder treatment across the life span, okay, and by helping to further integrate behavioral health with physical health, utilize evidence-based practices on a more consistent basis, and improve access to high-quality care. And then here is the kicker, to actually pay for the cost of the services.

So that, in and of itself, will improve the quality of the services tremendously because if you can infuse our behavioral health clinics with funding, you're more apt to keep people, good people who are highly trained and experienced and keep them trained and retain them. So, and then to provide the quality services.

So it is a really incredible opportunity, and for me, you know, I spent 30 years in

the field. I started as a student in Arlington County, Virginia. I was hired as a clinician when I finished, and I ended my career the last 12 years as the executive director of the Community Services Board, which oversees all publicly funded mental health, intellectual disability, and substance abuse services for the whole county.

And having that experience, and Arlington County, Virginia, is a very wealthy county. You know, there is 65, 69 percent of the funding that I had in Arlington County was local dollars. If I had to rely on the State dollars, block grant dollars, and Federal funding, we would have a fraction of what we had. We'd probably have about \$12 million to serve thousands of people a year.

So, anyway, this is an opportunity to really do something different and to engage people, to give them choice, to provide services that they want and they choose, to help them in their recovery, and to really provide them the tools necessary to live successful lives in the community. That's what this is about.

Okay. So next slide. All right. Here is five key pieces of the statute. If you can remember these five things, you understand Demonstration 223, at least the foundation. So the first thing that the statute says, you have to establish demonstration program criteria. And that was SAMHSA's job. So what are the standards that you are going to hold the States accountable, to hold the clinics accountable for?

So we had to develop criteria. We had to develop a prospective payment system, or PPS. You'll hear us say PPS a lot, really used primarily in the FQHC world. But a prospective payment system looks at the historical cost of a service and then will pay you for the actual cost. It's sort of a prospective. You look forward to say, okay, this is what we're going to provide, and this is what it's cost us to provide them. And so here is the true cost of our services.

And you can include -- lots of times people make the mistake of including just their clinical staff. Well, that's not the cost of your services. You have heating. You've got rent. You've got vehicles. You've got gas. You've got electricity. You've got administrative costs. You have to hire administrative people to say hello to people as they come in. Those are your true costs. So you put all that into the prospective payment system. So we're talking about true cost.

Once we did those two things, and we'll talk about them because we have done them, we then went on to awarding planning grants to States. So we said, look, this is exciting people out there. This is what it is. Are you interested? We did a huge blitz of the United States, and we then awarded planning grants to States. And I'll talk about that a little bit more.

So we've done up to number three. Number four is to select the eight States. We are now in the planning grant phase, and I'll go into more detail about that.

At the end of the planning grant phase, of the States who have a planning grant, we will select eight of them through a process to actually be in the demonstration.

So if you're not one of the eight, you're done. Okay? You're not part of the demonstration, and we are thinking about the rest of those States and what we may be able to do to kind of keep the energy and enthusiasm going.

And then the last thing that was part of the statute is to evaluate and submit -- evaluate the program and to submit annual reports to Congress, okay? So those are the bones of Demonstration 223.

Okay. The demonstration is in two phases. So we are in Phase I. SAMHSA has developed the standards or the criteria by which the clinics will adhere to and the States will hold them to and certify that they are actually using the criteria. And we can talk about the criteria a little bit. We've really upped the game with the criteria. This is not business as usual. We are not saying go forth and do what you're doing now, and we're just going to pay you for it.

No, we've upped what these -- the quality and the kind of services that people are going to be providing. We've developed a prospective payment system, and now we're in the planning grant phase. We awarded planning grants. We had a big process, and the majority of the States applied, which was just terrific. It was a competitive process, and we awarded 24 grants to 24 States -- they are grantees -- in October of this past year.

So from October '15 through October '16, we are in planning, and we're planning with those States on four critical key things, and you already know what they are -- certifying your clinics, developing your prospective payment system, getting ready for the evaluation, and soliciting input from your stakeholders in your States. And that's important for you to hear that. So each of those States has to go through a process.

So, and then we have teams, Federal partner teams set up to do the technical assistance to the States, and we are in the beginning stages of that. Phase II is the actual demonstration stage because in October 2016, the States will submit an application to be part of the demonstration. We'll have a review process for those 24 applications, and then the 8 States will be picked.

Those eight States can begin in January. January 1 is the start date, but we have a flexible start date because all the States are different. Someone said to me when I joined SAMHSA, if you've seen one State, you've seen one State. And that is just so true. Coming from Virginia, I think, "Okay, I know how things work," and that was not true.

So there's just different things those eight States will need to do to put everything into place to actually start. So January 2017 is the beginning of the

demonstration, and the demonstration runs for 2 years. We will have a full and robust evaluation of that, of the demonstration and then beginning in January 2018, our first report will be due to Congress, and our last report with recommendations is due 2021.

Okay. So here's how the eight States will be chosen. This is the -- this is what was in the statute around preference. So preference is given to States where the participating CCBHCs, their clinics provide the most complete scope of services. So the reviewers will be looking at that. It's really and/or, whose clinics will improve availability of, access to, and participation in services described in the criteria, whose CCBHCs will improve availability of access to and participation in assisted outpatient mental health treatment in the State and/or those who will demonstrate the potential to expand available mental health services.

And it says mental health services, and let me just be clear about this. It includes, fully includes substance abuse services. The language in the statute kind of went back and forth. It was actually called improving mental health, community mental health services. But the intent of Congress was behavioral health. So it includes substance use services.

And -- yes?

DR. DAN LUSTIG: I just want to make a recommendation.

MS. CYNTHIA KEMP: Yes.

DR. DAN LUSTIG: So much policy has been developed around the concept of behavioral health services, and in interpretation many States, they don't include addiction services.

MS. CYNTHIA KEMP: Yes.

DR. DAN LUSTIG: I understand the intent, but there has been so much policy written where addiction services are not included.

MS. CYNTHIA KEMP: Yes.

DR. DAN LUSTIG: And it's caused a complete disruption in certain areas of the country because of not mentioning addictions treatment.

MS. CYNTHIA KEMP: Yes. Yes, I completely understand. And when we wrote the criteria, and I can talk about it, we were clear and insistent that substance use -- substance treatment services were throughout the whole thing. Wherever it said mental health, it said substance abuse, or substance use. So the clinics have to provide those services, and they have to provide them in certain ways, and we are explicit in some ways.

Let me just say this because this is a bit of an interesting point. The substance use folks were a little slow to the table. I think they're onboard now, and I don't know whether it's because of the word, the language or behavioral health or the fact that it was called improving mental health, community mental health services. But we made calls to every State and talked with every State about what this demonstration was about, that it included substance use. And we have continued to stress that as we go along.

So, hopefully, that will make a difference.

MS. MARY FLEMING: And Cindy, this is a point of clarification. When you talk about CCBHCs -- you'll probably talk about this later -- but you're talking about the lead entity and any of its organizations that help create the entity that provides all the required services.

MS. CYNTHIA KEMP: Yes. Yes, yes, yes. I have slides further on. But that's a good point because I haven't defined CCBHCs to you yet, and these are providers in the community that have -- that the State has chosen through some sort of a process that have agreed to adhere to the criteria that we developed, okay?

And so they are -- they can be local, locally public services. They can be private nonprofits. They can be whatever, you know? They can't be for profit, but the State makes a determination as to what providers in their State, through whatever process they choose, they pick whatever clinic they want.

Now some States, they're certifying every clinic in the State. Most States are doing two clinics, one rural and one urban. And a smattering of States are doing between 4 and 10 clinics. But those clinics then become the certified community behavioral health clinics. They are the clinics that have to adhere to the criteria. They are the clinics that will get the extra dollars, the enhanced Medicaid dollars, prospective payment dollars, and they are the clinics that will have to be part of the evaluation.

So does that help? Thank you, Mary. I'm using CCBHC without really telling you what it was, I think.

Don't hesitate to continue to ask me questions. Okay. So that's -- that's the main criteria for choosing the 8 States that get in the demonstration, and the 24 States that are in the planning now, they are well aware that this is a competitive process. They have a one in three chance at the moment of actually getting in the demonstration. So it's a big deal, and we're seeing them working really, really hard.

MS. MARY FLEMING: And I also -- sorry to interrupt.

MS. CYNTHIA KEMP: Do you want to say the President's budget?

MS. MARY FLEMING: No, I just want to note that in the original estimates, this will bring another, based on the 8 States, \$900 million into those States. So --

MS. CYNTHIA KEMP: Over the course of the 2 years.

MS. MARY FLEMING: Over the course of 2 years. So it really does represent --

MS. CYNTHIA KEMP: It's a big deal.

MS. MARY FLEMING: -- a significant influx of --

DR. CAROLE WARSHAW: Nine hundred million?

MS. MARY FLEMING: Nine hundred million.

MS. CYNTHIA KEMP: More than \$900 million. It's almost a billion.

MS. MARY FLEMING: Yeah, it's almost a billion. And given that there are far more clinics participating, it may be higher than that.

MS. CYNTHIA KEMP: Yes. What I thought Mary was going to say is the President's budget. In the President's budget, FY '17 proposed budget, he has upped the number of demonstration States to 14 and added in millions of dollars to CMS to cover the cost of the extra 6. So we'll see. We don't know where that will go, and there is some effort under way to fund all 24.

Okay. All right. So I've talked about this a little bit. SAMHSA has the overall lead for the development of the criteria, the awarding of the planning grants. We are managing those grants now, and then we will produce the annual reports. CMS, or the Centers for Medicare and Medicaid Services, of course, they're involved in the prospective payment system. They have developed it, and they will monitor the payments during the demonstration.

ASPE, the Assistant Secretary for Planning and Evaluation, is doing exactly what their name says they do. They are involved in the quality measures, and they will be evaluating the program. We are working closely together. I talk to these folks pretty much every day. And then we are coordinating with other HHS agencies as appropriate, whether it's general counsel. HRSA has been terrific because Demonstration 223 and the CCBHCs were actually modeled a lot on HRSA. So the -- and the FQHCs that they have. So they're wonderful consultants to us.

All right. So here is the funding. We have already received \$2 million, and that was for the Federal partners -- ASPE, CMS, and SAMHSA -- to develop the

criteria, and we will be using it to do the annual reports and to develop the prospective payment system guidance. Twenty-four million went out to the States for the planning grants, slightly less than \$24 million. We suffered some sequestration cuts.

And then this, the way this is funded is through Medicaid payments, okay? There is no other funding connected to this when they get into the demonstration besides Medicaid.

All right. So here is the timeline very quickly. May 2014, the work began right after the -- it was signed into law by the President. May 20, we released our funding opportunity announcement for the States. The States reviewed it. We did a lot of prework with the States. Preapplication webinars were held, but we did a lot of calls and talking to the States about what this was and why it was important and why they should be interested.

August 5th, they submitted their applications. October, we awarded the planning grants. We are now in the October to October technical assistance planning grant phase. October '16, the applications will due from the States to participate in the demonstration. January 2017, we will select the 8 States to participate in the 2-year demonstration and then begin the annual reports.

We are ahead of the statute timeline. We were told it couldn't be done. We were told we needed to get it done, but it would be a challenge, and we are -- we are well ahead of the timeline. So that's -- the timeline that was in the statute. So that's good. I'm happy about that.

All right. So let me talk about the CCBHCs a little bit because I think this is probably what -- that's all background that I gave you. Yes?

DR. CAROLE WARSHAW: Is the idea this would keep going after the demonstration?

MS. CYNTHIA KEMP: Ah, we are very hopeful that it will keep going, but there is nothing at this point that is going to keep it going. I think the annual reports and the evaluation will inform Congress as to whether we keep it moving.

DR. CAROLE WARSHAW: There could be a gap --

MS. CYNTHIA KEMP: There could be a gap.

DR. CAROLE WARSHAW: Or there could be --

MS. CYNTHIA KEMP: There could be a gap. And believe me, the States are thinking about that because they are moving to expand their services. So, but it's a big -- it is a big deal, and I think it really is the future of how services will be

provided. So I'm very hopeful that the evaluation will be good.

I mean, we all know you provide good quality services that are accessible, that people want and choose, you engage people in services, you have a warm, welcoming environment, people come to those services.

So, anyway, here is the care. The care is community-based. It doesn't mean things don't happen inside the four walls, as CMS likes to say. But it's integrated. It is integrated within the community behavioral health clinic, and it's also integrated outside, and I'll talk a little bit more about that.

It's evidence-based or emerging best practices. It's person and family centered. It's recovery oriented. It is trauma focused. It's culturally and linguistically competent, and the services are coordinated. And that's -- that's what we're saying to the States and to the providers. This is the care that we're really looking for you to provide.

So let me talk about women and girls just a little bit because I know who you are, and I thought let me put in this slide.

DR. CAROLE WARSHAW: We're not all women and girls now.

[Laughter.]

DR. DAN LUSTIG: Thanks, Carole. Keep exploiting me.

MS. CYNTHIA KEMP: Well, but I know what you're about. Let me just say I know what you're about. Okay. So there's nothing in the statute specific to women and girls, but there's many, many opportunities within this demonstration to do a much, much better job than we're doing now.

So the first thing or one of the first things that the States need to do, the criteria requires it, is that they have to do a needs assessment. So who are the people that you're serving now? What are their needs? How best can you serve them, et cetera? And in addition to the people you're serving now, who's out there that you're not serving that you really should be looking at and thinking about serving?

So are there veterans? Are there groups of people that speak a different language that you haven't reached out to and engaged? What are their needs? The States are required to do a full and thorough assessment. We did a huge webinar earlier this month that went into lots of details on expectations around how they were to do the needs assessment.

We don't want them just to look at a chart, some census stuff, do some prevalence rates, and tell us. No, you have to tell us who you're serving, who

you expect to be serving, who is out there that needs your services, and what -- what -- what are their needs. And then that needs assessment drives what you do in that clinic. So your staffing follows it, okay? Your evidence-based practices follows it. Your hours of operation follows it. Everything is driven by the needs assessment.

So we are expecting that the States will look at the needs of women and girls, as well as people with different diagnoses, people who are in different parts of the system, whether it's the criminal justice system or the schools or wherever they are, that they're looking at those needs and then using that information to drive the kinds of services that they're providing. We see the needs assessment, or I certainly do, as the cornerstone of the demonstration.

So I know that you all know that there is just big difference between how women respond to treatment, the kind of treatment that women need or services that women need. They suffer different consequences related to substance use. They need different recovery support system so that we are working with the States to work with their providers to ensure that the kinds of services that people need who will be coming to the clinic are provided with in those clinics.

Yes?

DR. DAN LUSTIG: Is there a requirement in the CCBHCs about a period of time that you should have been billing Medicaid directly?

MS. CYNTHIA KEMP: You will be billing Medicaid using the prospective payment system and getting the enhanced dollars during the 2-year, but you're talking about prior to?

DR. DAN LUSTIG: Correct.

MS. CYNTHIA KEMP: No, I don't believe so.

DR. DAN LUSTIG: So that would be a State-specific requirement?

MS. CYNTHIA KEMP: Yes, I believe so. You reminded me of something else. You know, coming from the field, I thought I knew exactly what needed to go into this criteria, and I still think I'm right about it. But when I did the first round of the criteria and put it out for public feedback, oh, my goodness, okay?

Most of the -- well, we got a lot of feedback, and we had some feedback, a little, that said we hadn't gone far enough. But most of the feedback was we had gone too far, that we couldn't require so much of the States and the clinics because of where they were at. Some States, you know, are just -- they got it all going on or mostly, and some States are really struggling with providing even basic services.

And so we kind of set the bar up here, and the States were basically saying to us we're not even going to apply. I mean, we can't even meet it. So we broadened the criteria and loosened things a little bit while still keeping a focus on giving the States some flexibility but still telling them you tell us what -- what you're doing related to Medicaid. You tell us now. You tell us where you are with bringing in evidence-based practices, what the needs are, and what you're going to bring in now.

So instead of dictating it or requiring it, we gave them more flexibility. So the States do have a degree of flexibility in this demonstration while still upping the standards. This is my hope as we go forward. My hope is this demonstration becomes a reality and it starts, we'll see, and that SAMHSA owns the criteria and that we then are able to continue to issue new criteria that continues to raise the bar as we move up.

So were you going to say something, Mary?

MS. MARY FLEMING: Well, I was going to -- I don't know if you were also asking about did a DCO have to be a Medicaid provider and bill Medicaid prior to becoming part of the CCBHC? Because I think -- I think we're actually working on a contracting webinar for --

MS. CYNTHIA KEMP: Okay. I was going to say maybe I misunderstood your question.

MS. MARY FLEMING: Well, no. I think I may have misunderstood it. But part of what we're trying to do is I think that States have flexibility to do business a little bit differently than they did under their traditional Medicaid program.

MS. CYNTHIA KEMP: Right.

MS. MARY FLEMING: So one of the issues that we're sort of looking at and telling States to look at is look at your contracting processes and see to what extent they support or are challenges to operating in this environment, and can you change those for purposes of the demonstration? So can you bill under -- do you have to get a special provider, Medicaid provider number? Can you bill under the CCBHC provider number?

So there is a lot of that discussion going on. And to the extent the States will raise those questions up to the Federal partners, then we can develop a response to them. I don't know, Dan, if that's --

MS. CYNTHIA KEMP: Does that help?

DR. DAN LUSTIG: Yes.

MS. CYNTHIA KEMP: Okay. So let me talk about the criteria just a little bit more, okay? So this is the criteria that SAMHSA developed. The statute was very clear that there is six sections in the statute that have to be part of the criteria. And so there were staffing requirements. There were requirements around availability and accessibility of services, including 24-7 crisis services, sliding scales, and that everyone needs to be served regardless of ability to pay or place of residence, okay?

So even though this is a Medicaid demonstration, if you come in and you don't have any insurance at all, you need to be served by that CCBHC, and you need to be provided the same quality of services as everybody else. And if you don't live in the area of that CCBHC and you've come from somewhere else, they're required to provide you, at bare minimum, 24-7 crisis services. And then it's up to each State and clinic how they then will deal with you after that, whether they continue to provide services or whether they work with you to go back, you know, to go where your actual home is.

Care coordination is very important because the statute requires that there is care coordination across all kinds of services, and I've listed a few here, but it is an incredibly lengthy part of the statute. You have to -- the CCBHC staff doesn't have to provide these services directly, but you have to coordinate your care.

So the days of saying to somebody, "Hey, I think you need help with SSI or getting Medicaid or something. Here is a number, go across town, and get there." No. You have to make sure that that person is linked and you're monitoring that they've got here, that you're monitoring how they've done, and so the statute and the criteria require that there is actual agreements with these community partners.

So they are FQHCs, you have to coordinate with primary care. You have to coordinate with inpatient psychiatric services, substance abuse detox, substance abuse treatment services, residential programs, Department of Veterans Affairs, et cetera, schools, child welfare agencies, criminal justice, juvenile justice. Just a very long list of -- and I actually think I have another slide about it.

So these are the first three things that are required or sections that are required as part of the criteria. The fourth is scope of services, and there is nine services that the statute requires. And you know, we call them the "magic nine." Here they are, and these are the services that CMS will pay Medicaid funding for.

So the first four are bolded, and the reason they're bolded is because the CCBHCs have to provide those directly. These are basic core services that the main agency has to provide. Crisis services. Now crisis has a caveat. So I'll come back to that in a second. Screening and assessment. Of course, that makes sense. Patient-centered treatment planning, and then the outpatient services.

The next five services can either be provided directly by the CCBHC and/or in some combination with what we're calling a DCO. And my next slide talks about a DCO, a designated collaborating organization. And this was done to give the States and the clinics some flexibility around how they wanted to do that.

So suppose you're in a certain geographic area, certain section of a State, and the main mental health clinic has the four services, but they don't provide psychiatric rehabilitation services directly. They contract out day programming or supported employment or something like that. Or they contract out, they have a wonderful peer program that provides peer respite. We didn't want to say to the States, oh, sorry. You can't contract with those wonderful organizations anymore. You have to provide that directly.

So if you have good quality agencies, providers in your area, the CCBHC's area, you can contract with them. They become a DCO, and that DCO has to adhere to the same criteria as the main clinic and they receive the enhanced Medicaid payment.

So I have some slides I think that will help you in just a second. So let me just make sure I'm telling -- oh, let me go back to crisis. Crisis has to be provided directly. It is a critical core service, except if the some States have developed these kind of regional crisis programs because they're in like an area where it just makes sense to have a regional program that's funded either by all of them or through the State or some way, and everybody uses that crisis.

So if you have that and the State sanctions it, you can go ahead and use that. So, otherwise, you have to provide it directly. Yeah?

DR. DAN LUSTIG: So where would residential substance abuse treatment fall?

MS. CYNTHIA KEMP: Okay, very interesting. Substance abuse residential is one back. They're under care coordination. They are not required, a required service. They're not one of the magic nine. But you're required to coordinate care.

So they -- substance abuse, and the statute was very clear. You can't pay for any residential or inpatient services. This is they are not part of this demonstration. So we had no choice, but they're not part of it. But the statute was clear and the criteria is clear that you must coordinate your services with the substance abuse residential treatment facility or detox facility if they need it.

DR. DAN LUSTIG: So using the premise of integration, what was the thoughts behind not including residential substance abuse treatment?

MS. CYNTHIA KEMP: Okay. Well, that's -- I don't know what the thoughts

behind it was. It was Congress' thoughts. So they didn't -- and maybe it was expense. I don't know. I don't know why --

MS. MARY FLEMING: I think it probably related at that point from the IMD issue.

MS. CYNTHIA KEMP: Oh, it could be the IMD issue, sure.

MS. MARY FLEMING: That would be -- that would be my guess, Dan.

MS. CYNTHIA KEMP: Yeah.

MS. MARY FLEMING: Is that it came as a result of the IMD issue.

MS. CYNTHIA KEMP: That's a good point.

MS. MARY FLEMING: That's just a guess.

DR. DAN LUSTIG: Tell me -- I mean, what do you mean? I don't understand.

MS. MARY FLEMING: It's that there historically is not a responsibility on the part of the community behavioral health centers to pay for, and Medicaid does not pay for services that are in an IMD setting. So they would not include that in this prospective payment system. So I think in FQHCs, inpatient care is not included.

MS. CYNTHIA KEMP: Right. I believe that's correct.

DR. DAN LUSTIG: So you do understand now that that's part of the premise of why there is a deterioration of including substance abuse providers because, you know, one of the things that Illinois did is we required the State Medicaid director to have the managed care companies pay the IMDs because in this State and in many States, actually, the population that was not traditionally Medicaid but was part of the expansion was not.

And so now we're excluding access to care in yet a new demonstration project, and these are the subtle pieces to --

MS. CYNTHIA KEMP: Yeah.

DR. DAN LUSTIG: -- why is the addictions field so far behind or so slow to respond.

MS. CYNTHIA KEMP: Yeah, I hear your point. Absolutely.

DR. DAN LUSTIG: And it's really problematic across this country that we're not paying attention to getting addiction providers at the table and be as close to the same starting point as mental health and primary care. It's a huge issue in many,

many States, and this is yet another project that's repeating the issues that we've lived with for the last couple of years.

DR. SHELLY F. GREENFIELD: It's kind of ironic in the midst of an opioid epidemic and the need to extend care, and the opioid epidemic is only just the thing that's brought public attention to what's always been this tremendous untreated need of substance use disorders in the United States. And it's just sort of ironic to be doing this at this exact moment in time. More to your point, you know, it contributes to a deterioration rather than a better integration.

MS. CYNTHIA KEMP: I hear your point. I think it's a good point. I mean, I completely understand it. We are --

DR. SHELLY F. GREENFIELD: Mary raises the point that it's also an exclusion of any residential treatment in mental health also.

MS. CYNTHIA KEMP: Well, that's true.

DR. SHELLY F. GREENFIELD: They don't pay any residential treatment at all.

DR. DAN LUSTIG: Yeah, I think the premise is still there. I mean, still we're supposed to be looking at coordinating care, better access to care, improving quality, and this doesn't do it. This only does it for an area of services.

MS. CYNTHIA KEMP: What do you mean when you say that? Because I think it does improve the coordination. You are required, you're required to provide outpatient substance use services, and I'll talk about crisis in a minute because we're -- they are now required to include substance use crises in their crisis services. And it requires them to coordinate care with substance use residential treatment providers in the community.

It's not -- you're right that they're not part of the demonstration in that they're paid -- the required services are paid for, but they are required to coordinate that care and ensure that the person is getting the treatment that they need.

DR. DAN LUSTIG: So based on an integrated approach, why would we not bring residential to be the same part of the new payment system since that seems -- I mean, this is the issue around SBIRT. SBIRT is a great intervention for very small, select group of people. Your long-term addicts? SBIRT is horrific on.

And so when you have people with 20- and 30-year drug addictions and we're not going to include a level of care, I don't understand it.

MS. CYNTHIA KEMP: Yeah.

DR. DAN LUSTIG: And it really has been problematic, and I can only refer to

Illinois in this example. But when they did their 1115 waiver with Cook County, it almost bankrupted the addiction system because they built the platform for mental health and primary care.

MS. CYNTHIA KEMP: I see what you're saying. Yeah.

DR. DAN LUSTIG: And I'm saddened that we didn't take a stronger lead on this because this is happening all over -- this is happening across the country and that the way people are resolving problems are not through these CCBHCs, but they're resolving the problem through the 1115 waiver. And that's you're excluding a comprehensive integrated approach and level of care.

MS. CYNTHIA KEMP: Yeah, I understand what you're saying. I do. I do.

MS. KAREN MOONEY: And I think, you know, to piggyback on what Dan is saying, maybe they're solving it some places with this, maybe some places with 115(b) waiver. Some places they're just not solving it.

MS. CYNTHIA KEMP: Right. Right.

MS. KAREN MOONEY: And that's the -- that's the truth for a lot of parts of the State.

MS. CYNTHIA KEMP: Right, right.

DR. SHELLY F. GREENFIELD: In terms of the, as you said, the magic nine or others --

MS. CYNTHIA KEMP: Yes.

DR. SHELLY F. GREENFIELD: -- I was just curious about medication-assisted treatment and where that is.

MS. CYNTHIA KEMP: Yes. It's part of outpatient services.

DR. SHELLY F. GREENFIELD: And it's written into it as outpatient services --

MS. CYNTHIA KEMP: It's written into the criteria. It's --

DR. SHELLY F. GREENFIELD: -- including MAT?

MS. CYNTHIA KEMP: It's written into the criteria.

MS. MARY FLEMING: Cindy, even though it's a required service, the CCBHC, as I understand it, doesn't have to provide all of -- there could be capacity outside the CCBHC where they may --

MS. CYNTHIA KEMP: Through the DCOs.

MS. MARY FLEMING: For a DCO. So they may have as a DCO an MAT program --

MS. CYNTHIA KEMP: That's correct.

MS. MARY FLEMING: -- in addition to their own capacity to provide some outpatient substance abuse services.

MS. CYNTHIA KEMP: That's correct.

MS. MARY FLEMING: So it's not -- that isn't the sum total of the capacity in that area. Does that make sense?

MS. CYNTHIA KEMP: Yes. Yes, you are correct.

MS. MARY FLEMING: So we're not saying to every CCBHC, go start an MAT.

MS. CYNTHIA KEMP: No.

DR. SHELLY F. GREENFIELD: And if there is no MAT program in the area of the CCBHC, is there really sufficient resources to start one when it's a needed service?

MS. CYNTHIA KEMP: Well, there should be because you can bill Medicaid for the service.

MS. MARY FLEMING: It can be built into --

MS. CYNTHIA KEMP: It can be built into the prospective payment system.

MS. MARY FLEMING: While the PPS is built on "history" since it is a startup PPS, during the first -- during the planning period, the States will be estimating the cost of what it would be to operate in this fully functional capacity. So the PPS will be based on those cost estimates, not historical usage necessarily. There is some play in that.

So if, in fact, they have to build MAT capacity, they can build that into the PPS, as I understand it.

MS. CYNTHIA KEMP: That's correct. That's correct.

MS. MARY FLEMING: Yes.

MS. KAREN MOONEY: Yeah, and I think one of the things that's challenging about this, and from working with the Federal Government, SAMHSA really is a pacesetter with so many things and really drives what the States do, that if SAMHSA isn't specific in saying this is what you have to do with this money, it doesn't get done. Because people are doing business as usual already.

MS. CYNTHIA KEMP: Right.

MS. KAREN MOONEY: So if you say we expect you to, but it isn't written in the criteria that this is what you have to do, the States aren't going to do it.

MS. CYNTHIA KEMP: Yeah, there's a lot written in the criteria. They do have to develop evidence-based practice services or best practice services, based on their needs assessment. So they have to do that, and we're looking at their needs assessment and we'll see what it is they determined the needs were and then what services they have built, and then they can expand their services and roll those costs of the expansion into their prospective payment system.

And here is another thing. If they don't have -- currently have a service and it isn't in their State plan amendment to be paid for by Medicaid -- supported employment is a good example. They can build supported employment into their clinic, into their prospective payment system, and get paid Medicaid dollars for supported employment during the demonstration.

So they can -- they can look at only those clinics. Not the rest of the clinics in the State, only the clinics in the State that are the CCBHCs and part of the demonstration. So it's very important that they do a needs assessment. They determine what those needs are. They build those services in. The ones they don't have, they project the cost of them. I'm going to serve 1,000 people in supported employment at a cost of X. And they roll that in, and it all becomes part of the prospective payment system that they're paid for those. And they get paid for those services.

So it is a way of infusing those clinics with extra dollars to provide services, better-quality expanded services.

DR. CAROLE WARSHAW: So -- so, basically, people could do like, you know, the gold standard, whatever, you know, that everything that people might need, they'd build in and get paid for and have something really great.

MS. CYNTHIA KEMP: That's the plan.

DR. CAROLE WARSHAW: And so, being explicit about some of these -- some of the substance abuse related services, are you saying that having guidance explicit on that would be really to help sure that that's what people are thinking --

DR. DAN LUSTIG: Let's use an example. So what you have in certain States, and in Illinois specifically, is the people that are proposing to be the CCBHCs are adding and applying for licenses at their agency instead of trying to collaborate with what's already been built. So, you know, you have providers that are applying for addiction licenses that have never done addictions treatment before only to get --

DR. CAROLE WARSHAW: So they can get more money.

DR. DAN LUSTIG: So knowing that there's no supervision, so --

MS. CYNTHIA KEMP: Why would the State do that --

DR. DAN LUSTIG: Well, that's a great question.

MS. CYNTHIA KEMP: -- when they --

MS. KAREN MOONEY: Because you have to license anybody who applies unless you have a good reason not to.

MS. CYNTHIA KEMP: But the State doesn't have to pick them. The State -- it's up to the State to determine within their State am I certifying every single provider in my State? Some States are doing that. I think one or two. Other States are saying we're having a process here. Here is what we're doing. You apply. They look at all 400 applications, and they pick 5. And the State then determines what clinics they have and who their DCOs are. That's up to the State.

DR. DAN LUSTIG: But again, it would be helpful to have had a little bit more prescriptive language to guide the process by.

DR. HENDREE JONES: And it seems like the whole needs assessment, like how specific is that? How structured is that? Because that, the whole thing hinges on that.

MS. CYNTHIA KEMP: It does.

DR. HENDREE JONES: And if it's vague, we're totally -- the substance use folks are totally out in the cold.

MS. CYNTHIA KEMP: Okay.

MS. MARY FLEMING: One point to remember is that this will be a competitive process --

MS. CYNTHIA KEMP: That's just what I was going to say.

MS. MARY FLEMING: -- in the selection of the eight States. So, and we try to reinforce this in our conversations with the States. So we will -- not "we," but the reviewers will look at how was a needs assessment done? How comprehensive was it? Did it really address some of these issues?

I think we'll look at sort of how did the certification process go? I mean, there are a set of -- I mean, ultimately, decisions need to be made about what eight States are standing at the end of the day.

MS. CYNTHIA KEMP: The best eight. It's the best eight, going back on those four things.

MS. MARY FLEMING: So --

MS. CYNTHIA KEMP: The most expanded services, the most accessible services, the most coordinated services.

MS. MARY FLEMING: Right.

MS. CYNTHIA KEMP: Yeah.

MS. MARY FLEMING: So, you know, so I think your points are well taken, and we might think about them in terms of how the applications are reviewed and that sort of thing because there may be some ways that we can --

DR. HENDREE JONES: But also what you're looking for for the needs assessment. So the language that you write in terms of how you're asking people the different buckets for the needs assessment needs to be really carefully written because you're going to -- you know, if it's vague, you're going to get these States with --

MS. MARY FLEMING: Well, the guidance for the application process is already out there and done. It requires OMB approval, and you know, CMS will manage -- this is sort of it's an interesting intersection between SAMHSA's role and the role of CMS. So CMS will manage the actual demonstration.

MS. CYNTHIA KEMP: Right.

MS. MARY FLEMING: So I think, you know, as we look to score the applicants, maybe that's the next place where we can start to figure out where we might address some of these issues. But I also want to point out the issue about residential and inpatient is just statutorily defined. I mean, it is -- it is just clear in the statute. We -- we have no --

MS. CYNTHIA KEMP: We couldn't do anything different.

MS. MARY FLEMING: We have no wiggle room about that at all.

DR. SHELLY F. GREENFIELD: The statute with regard to this?

MS. MARY FLEMING: Yes. Yes.

DR. SHELLY F. GREENFIELD: I guess what I was thinking as I was listening to the discussion because, you know, I think obviously this is like a big program, and it's a major step forward toward things that, you know, I think everybody would endorse as being good things in terms of providing more integrated and better services, you know, for people. And I just think maybe it's just important to hear back from the field the unintended consequences that can sometimes happen that doesn't -- will in the end not necessarily achieve what you were hoping to get.

And that it's pretty typical in ways that substance use disorder services somehow get shunted over to the side in some way, and you know, the kind of necessary language to ensure that they really do get pulled in and integrated often just isn't there to make it happen. And that -- that -- and then, you know, downstream, as States are responding to what comes out, which is heralded and is, in fact, a really good thing in terms of more dollars going in the direction that you want it to go in, you find people on the ground like struggling all of a sudden with a system that's been built up that's good, that has expertise that now can't get the funding stream that it needs. It's getting shunted over to the side.

And so it's just -- you know, it's almost like a -- it's I'm not sure which things can be intervened on now, except within the demonstration project itself. But just it's kind of a major note to think about for the future. Because there will be more things, I believe, I hope, anyways.

MS. CYNTHIA KEMP: Remember, it is a demonstration program. And the other thing is we work very hard to make sure substance abuse was an integral part of the criteria. It is woven into the criteria everywhere mental health is. So it isn't we didn't leave it out of certain sections, and we work at -- here's an example. For crisis services, in most -- most. In the community behavioral health systems that I'm familiar with, if you are in crisis, it's you're usually talking about a mental health crisis.

If somebody is in a substance use crisis, they are told to go to the emergency room. They end up in the emergency room. Maybe a mental health person comes over 24 hours later, says, "You want to go home? Okay, go home." There isn't that -- there isn't that opportunity for real intervention there, to engage somebody and bring them into treatment.

And this changes that. Crisis services must include substance use crises, and it

talks about -- I'm sorry?

DR. DAN LUSTIG: As long as it's outpatient.

MS. CYNTHIA KEMP: No, addresses crises-related substance abuse and intoxication, including ambulatory and medical detoxification. And then we have defined what that means, and then you have to get the person what they need when they're in crisis. So you can't just send them to -- I mean, you may send them to the emergency room because you're concerned for their health and safety. But you can't just do that without following them, ensuring that that crisis is attended to and that they're linked and engaged upon the end of it, as that crisis is ending.

So it's an important part of it because that is often not done in community behavioral health or mental health centers. So that's an example of how we'd worked to kind of weave, ensure that substance use was -- substance treatment is really part of this. So I'm sorry. You had -- you were trying to say something.

DR. CAROLE WARSHAW: Yeah. I was going to ask where are the opportunities to add in things that we think are important, particularly like for women's mental health? Like what are the vehicles for providing input at this stage of the process?

MS. CYNTHIA KEMP: This stage, the States have been given their planning grants, and the criteria is written. And you know, we had a lot of input last year around the criteria. I think where you can give your input is in your own States. If you have a State that has a -- has a planning grant, that's an opportunity for you because one of the things that the States are required to do is to solicit input from families, consumers, and other stakeholders.

And they have -- each State is setting up a process by which they're doing that, and I actually brought the list of the 24 States. I thought maybe I could remember them, but I thought I should not rely on my memory. I can tell you what States those are. So I think your voice at the State --

DR. CAROLE WARSHAW: North Carolina is one of them?

MS. CYNTHIA KEMP: North Carolina is in. North Carolina is in. They did a great a job. I'll tell you who they are in no particular order. Here we go. New Jersey. Colorado. Connecticut. Iowa. Nevada. Oklahoma. Alaska. Michigan. New Mexico. Virginia. Massachusetts. Rhode Island. California. Illinois. Kentucky. Maryland. Pennsylvania. North Carolina. Indiana. Texas. Missouri. New York. Oregon. And Michigan -- Minnesota. I said Michigan already.

Twenty-four of them. So that's pretty good. I think we'll learn a lot, and I think as we find things that aren't working, that's our opportunities to change it or expand

it.

You know, when I -- when I started this, my thinking was, okay, we're going to build the best system ever, and that is still my hope. But -- or our hope. But you've got to start somewhere. You've got to start where the States are at, where the clinics are at. How can we get in there, infuse it with dollars, get the workforce that they need, expand the services, and really have the kind of accessibility and the kinds of services that people really want and need and that work?

So as we go forward, I am -- I am open to hearing your concerns and your voices. You'll be apprised as we go along, I'm sure. And I'm more than happy to come back. So I didn't quite finish.

Hi, Kana.

DR. CAROLE WARSHAW: What about for the evaluation process? Like, I mean, are there ways to add things into the evaluation criteria?

MS. CYNTHIA KEMP: The evaluation is in the process of being put together. So if you have ideas for the evaluation, maybe through Mary, I'm more than happy to hear your ideas. I talk with the folks at ASPE on a regular basis. In fact, I'm leaving here now to go talk to the folks at ASPE.

Let me just see if there's anything really important that I have to tell you. Oh, that's I talked about the DCO. Here is my favorite slide. Let me -- Kana, do I have a minute?

MS. KANA ENOMOTO: Of course.

MS. CYNTHIA KEMP: Okay. So here, see the big yellow circle? The whole circle, those are the magic nine, okay? Those are the services that were required in statute that are part of the criteria. The four green ones in the middle, those are the ones that the clinic must provide directly. The other five orange ones circling around the outside, you can -- the clinic can provide them directly if they want to and the State approves, or you can contract with a provider in the community that's already existing to do that.

You develop a formal relationship with that agency, and the agency must adhere to the same criteria as the main clinic and they get paid the enhanced Medicaid prospective payment system. The little "r" down at the bottom is referrals. There are services that would -- you know, that you would refer to outside of those nine, and those are outside the prospective payment system and don't have to adhere to the criteria.

And then here is the care coordination partners. I can't -- my eyes are bad. I'm

too old now. But along the side, there's all the partners that you have to coordinate care with. It's required that there is an agreement between child welfare, the schools, criminal justice, juvenile justice, et cetera. There's an agreement for how those services are coordinated. Substance use treatment, detox, et cetera. How that clinic will coordinate with these community partners.

Now the community partners are not part of the CCBHC. See, they're outside the circle. They're providing services or --

DR. DAN LUSTIG: Because the services aren't --

MS. MARY FLEMING: Well, some of the -- yeah, go ahead.

MS. CYNTHIA KEMP: The services are not paid for as part of the prospective payment system. They don't have to follow the criteria, but they're important community partners for which we must coordinate the care of each individual. Okay. So I only got up to four. There are six, six parts of the criteria. Number five is the quality reporting, which has to do with the collection of data and the evaluation. And last is organizational authority, which is really who can be a CCBHC, and what kind of governance does that CCBHC have to have?

I kind of said these things. Here is the major work we've done to date. We've been meeting since May since the statute was pretty much signed, lots of listening sessions. SAMHSA, ourselves, I think had four -- three major listening sessions, where we got incredible amount of feedback that we had to go through and, you know, often very conflicting feedback and tried to balance with what would work with still lifting up the clinics into a much higher quality of accessible care.

You've seen, I think -- okay. That's the end. All right. Well, thank you for having me. I've really appreciated being here. I've appreciated your comments. I look forward to hearing more of them, and I'm happy to come back as we roll forward.

Okay? Thank you.

[Applause.]

[Pause.]

Agenda Item: ACWS Future Priorities: A Conversation with Acting Administrator

MS. MARY FLEMING: Welcome, Kana and Tom.

MR. TOM CODERRE: Thank you, Mary.

MS. KANA ENOMOTO: Thank you, Mary.

MS. MARY FLEMING: We've already had a really kind of robust discussion today.

MS. KANA ENOMOTO: I bet.

[Laughter.]

MS. MARY FLEMING: And two issues that I know are going to come up. One is Carole had expressed some interest in talking a little bit about AOT, particularly I think the evaluation component of the grant program. And Dan, I don't know if you want to sort of continue your discussion because I think it's an important one about -- and it really has to do with I think SAMHSA's role in leadership around certain issues, particularly around true integration of the range of substance abuse services. And it kind of gets to the IMD issue, and we were noting the exclusion, and it's by statute, of residential and inpatient services in 223.

But sort of in the longer, greater scheme of things, do we have a leadership role around some of these discussions? But I think Dan can articulate it very clearly. Those were two of the issues that have come up so far. We've talked a lot about a lot more, but --

MS. KANA ENOMOTO: Great. Great. All right. Well, I would expect nothing less than active and robust dialogue with this group. But I do want to start off by thanking Mary Fleming for assuming this new role as she is transitioning to the National Policy Branch and agreeing to shepherd the ACWS along.

And I also want to acknowledge Sharon Amatetti, who is a tremendous leader for us on women's issues in CSAT in particular, but really SAMHSA wide and really across Government. She's so active, and hopefully, you saw the article in ADAW on PPW. Just -- did it come out yet?

MS. SHARON AMATETTI: I think it came out yesterday.

MS. KANA ENOMOTO: Did it come out yesterday? So Alison Insinger, who did a very nice piece on issues of neonatal abstinence syndrome, treatment for women with substance use disorders, and had interviewed Sharon, as well as a number of leading experts in the area. But Sharon did a nice, nice description of what SAMHSA was proposing, as well as other resources that we have, like the National Center for Substance Abuse and Child Welfare in partnership with ACF.

So thank you. But both of these women are fantastic. And oh, am I not loud enough?

MS. MARY FLEMING: We've been suffering this all day.

MS. KANA ENOMOTO: Uh-oh. Okay. All right. Well, I'll put my hands down. Maybe that will help also.

But, so I'm just -- I'm very appreciative of these two women because I would not want to have left this particular group in any less capable hands and with less strong leadership because this is -- these are issues and this is the population or these are populations that are super important to me personally. And it's a group that I have been with. Since 2005, I've been chairing, I think, the ACWS. So it is a while, and so we have very, very capable and expert leadership here. So thank you for bearing with us in this transition.

And I have with me today someone you've probably met before, but now he's had some time in the new role. Tom Coderre, who I asked to be chief of staff, as I am in the role of Acting Administrator. So do you want to introduce yourself a little bit, Tom?

MR. TOM CODERRE: Sure. I know some of you around the table, and others I'm meeting for the first time. But my name is Tom Coderre. I'm a political appointee in the administration. I came to SAMHSA back in August of 2014 as a senior adviser to Pam Hyde. I soon thereafter ended up as a senior adviser to the acting CSAT Director, and then in August of this year came back -- August of last year came back upstairs to be the chief of staff.

So in that role, I've been continuing a lot of the projects I've been working on -- the Behavioral Health Coordinating Council, the Interagency Coordinating Committee for the Prevention of Underage Drinking, working on the Surgeon General's report. And then Kana has asked me particularly to pay some attention to the work that we're doing not only interdepartmentally and with the White House and throughout the Federal Government with those projects, but also to pay particular attention to our stakeholders. And our most important stakeholder is Congress.

And many of you know that we have -- we have had some challenges there, and just to be honest about it, we've had some challenges communicating with Congress. And so what we've done is created a whole strategy around trying to improve that level of communication. Kana has been to the Hill on several occasions to do just that. I've worked with a lot of our leg. office and our expert staff here at SAMHSA to provide the Hill the technical assistance that they have asked for on a number of the initiatives that we are working on and many of you probably saw in our FY '16 request. On the Consolidated Appropriation Act, SAMHSA did very, very well.

So I think the strategy that we're employing is working, and a lot is going to be known when we get through this legislative session exactly how well we do. But

we are -- we are focused like a laser beam on that particular relationship with Congress.

In addition to that, we're also reaching out to all the stakeholders that we touch, and there are many. Whether, you know, because of the depth and breadth of the work that SAMHSA does, we have a lot of partners. And they are wonderful relationships, and what relationships take, as many of you know, they take work on both sides where you have to -- you know, you have to communicate. You have to engage. You have to work together.

You won't always agree, but at the end of the day, you want to walk away from the conversation knowing that you tried as hard as you could to reach consensus. And so we're doing that with a lot of our stakeholders, and it's been a great opportunity.

So in the remaining time that I have here in this administration, I'm going to continue to work as hard as I can to support Kana and the team in the Office of the Administrator and throughout SAMHSA and work with as many of you as possible to get our goals accomplished.

Thanks.

MS. KANA ENOMOTO: Thank you.

MR. TOM CODERRE: Thank you.

MS. KANA ENOMOTO: He's doing -- he is doing great work. I mean, we have an increase in FY '16. The administration is proposing a \$600 million, almost \$600 million increase for us in FY '17. You know, it's a vote of confidence. It's a vote of commitment and recognition of the importance of these issues and the ability of SAMHSA to help get work done. So we're really, you know, feeling like we're just sort of turning the corner --

MR. TOM CODERRE: Absolutely.

MS. KANA ENOMOTO: -- much more optimistic and, you know, ready to get work done and feeling like we're being supported to get work done. So I'd love to talk to you guys more about the AOT piece, the PPW piece, the integration. So do you want to lead it off?

DR. CAROLE WARSHAW: Okay. So I also want to hear, when Peggie was here, I guess, about what your sense is of where things might or might not be moving with mental health reform. Because there's lots of different pieces out there, and I don't know if you have a better sense because people have been following it. So that was another question at this time, and what kinds of things can help to support --

MR. TOM CODERRE: Yeah. We're in the middle of it right now. So it's --

DR. CAROLE WARSHAW: Yeah, we've been trying to track it as much as we can.

MR. TOM CODERRE: Yeah, it's a little difficult to say where we're going to end up. But it appears as though mental health legislation is moving through Congress and that we'll see something pass this year. We've been told by several members and staffers that they can't go home without bringing something back with them in this year in particular.

So we're working extremely hard to provide technical assistance. What the final outcome is going to be, what the bill is going to look like, we don't know. There are competing proposals, House and Senate proposals, and then within each chamber, there are competing interests to have certain things included in each of the bills. I don't know if Peggie covered much of it with you. But to get into a lot of the details about it might be --

DR. CAROLE WARSHAW: Another time.

MR. TOM CODERRE: Yeah, it might not be helpful because we don't know what's going to pass. There is -- you know, we have and Kana has been talking with the members about the importance of a strong SAMHSA and maintaining a strong SAMHSA. And what that means is different for everybody. And we're trying to make sure that we communicate with our stakeholders about what they think an important SAMHSA looks like and making sure that they communicate with members of Congress about what they think that looks like.

So we're hoping -- we're very hopeful. We've -- the initial reports that there was going to be a bill that gutted SAMHSA or destroyed SAMHSA or reorganized SAMHSA in a way that was unpalatable we don't believe will happen anymore. We believe we're over that hump. We believe we're now talking on the margins about where we can improve this system and where we could improve SAMHSA to deliver services in a better way.

So I don't think we're -- I think we're in a much better place than we were probably the last time you guys got together and --

DR. CAROLE WARSHAW: Do you have like talking points that you can share with us?

MR. TOM CODERRE: Yeah, I think we do. I think we can -- we do have a one-pager --

DR. CAROLE WARSHAW: Yeah, that would be helpful.

MR. TOM CODERRE: -- of some of the major points that are in each of the bills, and we can get that out to you.

MS. MARY FLEMING: That would be helpful.

MR. TOM CODERRE: Yeah. Yeah, we can do that. Absolutely. Thank you for asking.

DR. CAROLE WARSHAW: So the AOT issue, I mean, we've written like to the Senate HELP and Energy and Commerce about concerns about AOT and some of the HIPAA, loosening HIPAA violations particularly around coercion that we know that abusers do. They deliberately try to access that information, and we have stories from the field. We have some data, but not -- we're gathering more.

So one thing, since you seem to be mandated to do something with that, is in the evaluation and demonstration to really look at coercion in that -- in the AOT process, whether it's from a partner or a family member or someone else. And to really -- I mean, I'd be happy to think about it with you. But to really look closely. We hear stories about it happening around inpatient commitment, and then it gets used against women in custody battles.

But we don't know about outpatient, and we've been asked about that. We don't have that data. We're going to try to look, but if that could be built in, that would be great.

MS. KANA ENOMOTO: Right.

DR. CAROLE WARSHAW: Both as a protection and as a way to really make sure that it's done well if it's going to be done.

MS. KANA ENOMOTO: Right. Well, I think you can assure that given the strong feelings that there are from different parts of the field about AOT, that coercion will have to be one of the things considered in the evaluation somehow. There are things specified by statute that we have to look at as outcome. So housing stability, criminal justice involvement, health and wellness, homelessness. I mean, those are things that there are some items that the statute tells us to look at.

Let's see, oh, hospitalization and health and social outcomes.

DR. CAROLE WARSHAW: So, well, one of the questions is, you know, with the CCBHC, if you actually have really comprehensive, you know, state-of-the-art services that prevent people from needing, you know, for coercive services. And since you're including that in some of the demonstration criteria, is there a way to look at if people have everything they need on the front end, does that reduce the

likelihood that people might even -- that AOT might come up as an issue?

Because like with the Cochran review, it's like there's not a difference if you get the services than -- so to kind of build on that, is that what you were thinking about that already?

MS. MARY FLEMING: The -- as States apply for the demonstration grant, they have to pick one of four -- I think it's four or five objectives that they want or outcomes they want to achieve, and one is specifically related to a reduction in the use of AOT.

DR. CAROLE WARSHAW: Oh, reduction in the use?

MS. MARY FLEMING: Yes. So, so that is actually one of the areas that a State can apply to demonstrate the impact of a comprehensive array of services on the need for assisted outpatient treatment.

DR. CAROLE WARSHAW: Okay. That's great.

MS. KANA ENOMOTO: That's on the 223.

MS. MARY FLEMING: 223 side.

MS. KANA ENOMOTO: Yeah.

MS. MARY FLEMING: On the 223 side.

MS. KANA ENOMOTO: Right. But that's an opportunity to kind of do that piece -
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MS. MARY FLEMING: Yes. And so that also then would be folded into part of the evaluation of the 223.

MS. KANA ENOMOTO: Right. But we don't know yet if we're going to have comparison sites on the AOT program. It's not a very big -- I mean, it's \$15 million, but that's supposed to go to grants. So how much of that we can carve out for an evaluation is yet to be determined.

We're working with NIMH and ASPE. NIMH has agreed to lead on the evaluation, and so, you know, they would like to do something very robust with comparison sites. We'd like to do that as well. We just have to look at cost.

You know, there is what we're required to do by statute, and then there is sort of what we'd like to do and figuring that out because there's a high priority on getting communities funded with the grants. So that's always the tricky balance that we have. But I certainly have heard for the need to seek balance and to look

at the comparison with robust community-based services.

Certainly, we don't think AOT is a first-line intervention. It's not optimal. But at the same time, it can be lifesaving for some people, and it can be lifesaving for families. And we want to make sure that we can identify ways to make AOT work in the best, most humane, respectful way possible that gets the best outcomes that we can for the folks we care about.

So I'm comfortable that ASPE and NIMH share those goals with us, and in fact, we're having a phone call on Monday with Acting Director Bruce Cuthbert of NIMH and Richard Frank and myself to discuss evaluation. So I can bring this up. So you're very timely in the comment.

We were actually just asked questions about this at the Hill yesterday. So there's interest on all sides, and it's something that SAMHSA will have to navigate very carefully and sort of just maintain the true north of trying to do the best for the most people that we can.

DR. CAROLE WARSHAW: Let's have you hold all those things in the best possible way.

MS. KANA ENOMOTO: Yeah, yeah. Exactly. So the -- and on the privacy issues, you know, we have conveyed that -- that I mean, first of all, we think that advance directives are a really great option for most people, that when people aren't in a place to make good, you know, decisions. So we think advance directives are a good option for most people who find themselves in the -- in those kinds of situations or needing to be -- who get -- who from time to time are incapacitated by their mental illness or what have you.

And so we've talked about the HIPAA issues with Mr. Murphy. The Secretary is aware. We briefed the Secretary that one of the reasons why you cannot do a blanket -- why it's challenging to do a blanket waiver to any family member to access treatment information is because the family member is not a family member is not a family member. And so we -- you know, how do we -- we cannot pretend to know.

While most the vast, vast majority of family members have every good intention for the patient that they're caring about, we don't actually know that. And so not every patient has the same relationship with their family members that we would wish that they have. And so --

DR. CAROLE WARSHAW: And also if there's guidance on advance directives, you know, including like having that time to talk to someone about who is the person who is your attorney-in-fact and whether there is someone who is controlling your life or not. And --

MS. KANA ENOMOTO: Right, right, right. So we have raised that, and we've also raised that providers under HIPAA can disclose certain information if it is --

DR. CAROLE WARSHAW: Already.

MS. KANA ENOMOTO: -- the parents', if it's in the patient's best interest. So, you know, we have -- we have shared that, and that's been in the technical assistance that we've provided to the Hill. We are in line in recognizing the issues that you're talking about. Absolutely, yeah.

But it's hard for people to think about that. When you see many families who haven't been given information because their physicians didn't understand HIPAA well enough. So I think there are also plenty examples of where things did go wrong.

DR. CAROLE WARSHAW: Yeah.

MS. KANA ENOMOTO: And so, you know, I've lived that in my family, and I'm sure other people have lived that in their families where someone gets released from a hospital, and no one is told when or where or how. And it's -- you know, and it's not a good outcome. So --

MR. TOM CODERRE: That's a problem definitely. But the additional problem is, is that there's a lot of misinformation that's going around on the Hill about what can be done and can't be done. And so trying to -- oh, sorry. I was talking about the misinformation that's going on around the Hill about what can and can't be done with regard to that. And so we're trying to educate people best we can to let them know what the full array of things that can be done are.

MS. KANA ENOMOTO: Yeah, yeah. So, thanks.

MS. MARY FLEMING: Other things for Kana? Dan, did you want to bring up your --

DR. DAN LUSTIG: My what?

[Laughter.]

MS. MARY FLEMING: -- the IMD issue, the integrated systems issue?

DR. DAN LUSTIG: Oh, like were on the CCBHCs?

MS. MARY FLEMING: Yeah.

DR. DAN LUSTIG: So, you know, Illinois is one of the States that has been awarded the CCBHCs. But what I'm seeing is that because the language isn't

specifically specifying addictions, it's not -- I would hope that SAMHSA would have more of a supervisory role in how the addictions field is included in CCBHCs. So you have outpatient that's involved, but not residential treatment.

And so I can speak to the experience where 2 years ago, when Cook County Hospital applied for 1115 waiver -- actually a little bit longer than that -- and they stipulated one sentence about how addictions was going to be handled, when they were awarded this waiver, because they built it on a mental health model, the entire addictions field, except for outpatient, was excluded. And so it created a service nightmare for people accessing care.

And the language issue that I'm seeing all over the place is that people feel so excited when they say behavioral health because it's supposed to assume addictions. It is almost invariably never the case that addictions is included. Mental health still takes the lead, and systems are being built with that. And I think, for the addictions field, we're at a tipping point because so much is not including addictions at the table.

I can include managed care. Managed care doesn't know necessarily how to work with addiction providers if they're not licensed with their own NPI numbers. And so, as we look at the CCBHC rollout, it would be my hope that SAMHSA could provide a supervisory role of, you know, this is what this should be including and it be inclusive. I think because it's being left to the States, it's open for a mass interpretation of what the statute reads, and I think it's really problematic. I mean, I've been bathed in this for 3 years, and I only see us going backwards, not forwards.

And I think addiction providers are continuing to be pushed out of the way, and I think that creates an access to care nightmare. And it's just -- that's I even see this in some of the materials today. So it's just worrisome. It's really problematic in many States. And I --

MS. KANA ENOMOTO: Yes.

DR. DAN LUSTIG: And I'm sorry. And I see that, you know, I understand that many States are trying to fix their systems through 1115 waivers and other things, but when you have a new model, like CCBHCs, coming out that we're going to exclude certain service categories because we want to test out a model, we will never bring addictions to the starting level of mental health and primary care. We will never get there, and that's really what, I guess, part of my points were all day.

MS. KANA ENOMOTO: And you told Cindy?

DR. DAN LUSTIG: Yes.

MS. KANA ENOMOTO: Good.

MS. MARY FLEMING: And we talked about the sort of legislative prohibitions around the payment for residential and inpatient care in particular. That that sort of in some sense --

MS. KANA ENOMOTO: It cuts it off at the knees.

MS. MARY FLEMING: Yeah, we're really cut off at the knees with respect to that. But I think Dan raised a point that -- that what they're seeing, at least in Illinois, and I think, Karen, you said you're seeing it in other States, is that I think our expectation that providers would collaborate with one another is not quite the norm. That what you're seeing is more of a building more capacity in a CCBHC world, as opposed to, you know, is that an unintended consequence or not?

So they're not seeing that kind of collaboration. So substance abuse providers are, I think, feeling marginalized and, more than that, endangered. Is that a fair statement?

DR. DAN LUSTIG: Absolutely.

DR. SHELLY F. GREENFIELD: And I think also, just to add, like in terms of specifying what you need -- oh, I'm sorry. In terms of specifying what is meant by addiction services, that's another thing because if you took a general poll of people across the country as to what they think that means, that actually varies quite a bit. And unless you are spelling out that you also are including medication-assisted treatment for the range of folks that should be included, which are like adolescents, pregnant women, postpartum, adults, older adults -- the whole range -- you know, that is not necessarily -- I mean, I know for a fact that's not actually the way people consider addiction treatment.

And so it's really sort of saying addiction treatment needs to be integrated and specifying how, but also what's the range of services that would be expected. And so these are just things in terms of moving forward and hoping and trying to set the expectation and the environment and the regulatory environment that will actually enhance the opportunities for the States to actually do more of this cross-integration. Unless the things are spelled out, you can't assume that that's actually going to happen because, you know, we've been hearing a lot of reports around the table all day that that's not really what's actually happening.

So it's like an unintended consequence of something really good, you know? And not actually moving the dial in the direction we wish it to go in. So I was just curious, and I didn't want to interrupt this train of thought, but just kind of where things -- if you have a sense in terms of medication-assisted treatment and greater access in terms of where things are with SAMHSA and the greater stakeholder issue that was raised earlier?

MS. KANA ENOMOTO: So that's a good question. The CSAT is talking about that question all day today.

[Laughter.]

DR. SHELLY F. GREENFIELD: I know. I would split myself in half and go in both directions, but --

MS. KANA ENOMOTO: Yeah. So I think, to the CCBHC point, you know, we are the -- we certify the certification program. So we can, I think, look at that, and we can also talk to the TAP people who are out there providing TA, many of whom you know already, about -- on that. But ultimately, when it goes into a demo, it's CMS and not us.

But there is probably still room at this point. People are anxious. They want to get into the demo, and that's a bit of leverage to say these might be some of the things that we're looking for. True behavioral health, you know? Not lip service to behavioral health type of thing. Or how well defined is your benefit. So I think we can maybe look at that certainly.

I mean, it's good to know that that is an unintended consequence of the broad language. I think, you know, when you're trying to come up with criteria for something as important as this, there is also a lot of pressure from States and providers not to be overly prescriptive, right? Don't make it so difficult that no one -- I can't get anyone certified. Don't make it so difficult that, you know, 9 out of my 10 providers won't be eligible from the get-go. Don't make it so expensive that it's cost prohibitive for me to start to participate. Then I'm not going to apply for the planning grant or the demo.

So, you know, we're trying to balance things, and you know, we can only take it so far because people are -- they are taking on risk themselves by standing up these certification programs and getting their programs fitted out to meet the criteria because they may or -- right now, they have a one out of three chance of even getting the PPS. And then once you get the PPS, you have to bill Medicaid before you get reimbursed at the enhanced rate.

So the -- you know, the potential benefit is long term and significant, but the immediate risk is pretty high. And so, you know, you're all thinking about, well, if this becomes permanent and these are the criteria and this could be -- sort of set us back for a very long time in a not good way. And that's a good way to think about it, but I think we have to balance things with if we make the criteria very stringent and are, you know, very detailed, then nobody wants to apply.

Then we don't get a demo and -- or once we get a demo, people say this was way too expensive. This was way too hard. We don't need to make it permanent

law. And so thank you for the demo. Good-bye. Go home. Good luck with your now defunct CCBHC.

DR. DAN LUSTIG: And I think to that point, I would have thought that addictions would have been more integrated in this because they are typically high-cost individuals to the Medicaid system. And so that's -- I'm just really speaking to a point of a larger issue, that this is yet another example of an experimental demonstration grant that doesn't bring addiction services to the same starting point as mental health and primary care.

MS. KANA ENOMOTO: Yeah. I think there's some history to that, and I don't think -- I think now that there's a party. People are saying, well, why didn't I get more invitations? Like, well, if you came to the planning of the party, I would have given you just as many invitations as you wanted. But now that it looks like a fun party, you want to be here.

So, you know, I think there is some -- there is some conversation to be had about how we got to the place that we're in. But certainly now that we're here, I'm happy to try to not -- you know, to make the best of it and see if there are some fixes that we can do to the -- within our --

MS. MARY FLEMING: Yeah, and I think the clarification around the criteria, and Cindy made the point, I think, that as the criteria were written, that the intention was that every step of the way to include substance abuse services. It's probably because of these, of the term "behavioral health," not as explicit. So can we message that? I think so.

We did talk about the sort of eight States standing that as we look to evaluate those applications, that we're also saying you all need to do the best job you can, respond to the needs assessment, have robust evidence-based practices of which MAT is one of them. So we're trying to sort of recover in that sense.

MS. KANA ENOMOTO: Yeah, yeah. And so then on the MAT point, did you guys talk about the budget proposal?

MS. MARY FLEMING: We went over it very briefly with Peggie. Peggie went over it very briefly. So --

MS. KANA ENOMOTO: Okay. So we're -- we're -- first of all, we're really happy about FY '16. We have, I mean, you know, the AOT grant is -- while some would see it as controversial, I do see it as an opportunity, and I think it's a step forward instead of backward in terms of, you know, it's not -- it's a way to look at it, at that particular issue where we have some flexibility and we have some ways to direct how the grants are shaped and how we evaluate it. So I think it's actually quite positive.

In addition to the AOT grant, we have new money for MAT. So we have 25 more, \$25 million for what we fondly call MAT PDOA. It's a prescription drug and opioid abuse, I think? We also got -- opioid addiction, I'm sorry. We also got new grants in FY '16 for naloxone, as grants to States to purchase and distribute and train folks on naloxone. We also got grants for our long-desired, many times pitched SPF-Rx, the Strategic Prevention Framework for Prescription Drugs.

So really, the Secretary's initiative on opioids involves prescriber, improving prescribing practices, increasing access to MAT, and increasing access to naloxone. We have long said there also needs to be a piece about community prevention, primary prevention, and that SPF-Rx will let us do that. Many people who end up on heroin started on opioid analgesic, and so we know that there is an opportunity to talk to folks and get them before the problem starts and to identify -- using PDMP data, sort of identify some of those communities that are at highest risk and do that.

So that's in FY '16. Plus, we got an expansion by \$25 million, so it's a 500 percent expansion of our tribal behavioral health grant. So we're expecting to reach 100 tribes to do suicide prevention, substance abuse prevention, mental health promotion for Indian youth, American Indian and Alaska Native youth. And so that's going to be a really cool opportunity to let tribes identify what outcomes that they want to -- they want to use, they want to measure and define their own approaches to doing that in their communities.

So that's, to me, a vote of confidence from Congress in what we're -- what SAMHSA is doing, what we're capable of, and how they want us to lead. And then the vote of confidence that we got from the administration is a \$590 million increase in FY '17 and then a proposed, you know, maintenance of that. So one-point almost 1.2 -- yeah. So \$600 million in 2 years. So \$1.2 billion over 2 years.

So our budget is now \$4.3 -- our proposed budget is at \$4.3 billion. So that's a huge, huge increase for us. And so the \$950 million of the \$1 billion for the President's opioid initiative is coming to SAMHSA, on those -- that's formula grants to States to do MAT, also to provide recovery support services, do prevention work, and build the workforce.

Another piece in that opioid, the \$1 billion opioid initiative includes \$50 million to build out the behavioral health workforce at HRSA with the National Health Service Corps, with a particular focus on providers who can do MAT. So that would be --

DR. SHELLY F. GREENFIELD: But not physicians.

MS. KANA ENOMOTO: The National Health Service Corps doesn't include physicians?

DR. SHELLY F. GREENFIELD: In what I've just looked at, unless I'm incorrect. I was just looking at -- I think it doesn't have physicians. You're talking about the waiver for student loan debt or something else?

MS. KANA ENOMOTO: I'm pretty sure that the National Health Service Corps includes physicians.

DR. SHELLY F. GREENFIELD: Well, it does include physicians. I was just wondering about in terms of building the workforce, what the -- whether the incentives actually included physicians or other allied providers?

[Crosstalk.]

MS. KANA ENOMOTO: I can look into it. It's not -- it's not a --

DR. SHELLY F. GREENFIELD: I'm just -- I understand. Yeah, yeah.

MS. KANA ENOMOTO: -- SAMHSA program. It's a HRSA program, but I can look into that.

DR. DAN LUSTIG: Is there a SAMHSA program for building the workforce?

MS. KANA ENOMOTO: So in 2017, we do have a couple of proposals that are workforce oriented. One is the continuation of our Minority Fellowship Program, which does include physicians, psychologists, social workers, nurses, counselors, and MFTs? I'm sure there are a couple other initials that will get added on one of these days. But, so quite a few of the guilds are participating in our Minority Fellowship Program. That program has doubled over the last 3 years. So that's very positive.

Then we also have a \$10 million proposal for peer -- peer workforce. And then our -- what the other major program we had at \$25 million is the behavioral health workforce education and training, which did not include physicians. And that is going over, moving over to HRSA.

DR. DAN LUSTIG: So the minority fellowship, how are we defining counselors?

MS. KANA ENOMOTO: How are we defining counselors? I could check for you.

DR. DAN LUSTIG: Are they licensed people? Are they certified people, like certified addiction counselors?

MS. KANA ENOMOTO: I believe they are master's and Ph.D. level counselors. And I cannot remember which of the associations got the grant, but we can find that out.

DR. SHELLY F. GREENFIELD: I just want you to know that I think -- often talk about this so I just feel like I need to say it because we're talking about building the workforce. And it is really important. I'm sorry. I was saying that I often make this point when we talk about building the workforce, especially for treatment of substance use disorders, that we often are trying to enhance incentives for a range of health professionals. And often physician, the physician workforce has been left out of those incentives.

And it's extremely important that there are incentives for the physician workforce to train to provide treatment for substance use disorders and to understand, both in mental health settings -- so that would include psychiatrists -- and then in other, every other primary specialty, that they are qualified and are incentivized to train and understand what is necessary to provide that or to coordinate care. And often trainees are -- trainees all the way up through practicing physicians are left out of many of those kinds of incentive programs.

So just in terms of that, I just wanted to make that -- make that point. Because I know that a lot of these are located at HRSA, not here. But as I hear that, you know, things may move out also further programs from here to HRSA, I just would like to say that every time a program comes through where the physician workforce is not included, I think it is, to some degree, problematic in terms of the workforce capacity. And you know I've been very involved in that.

MS. KANA ENOMOTO: Right. So I can't -- it's surprising to me to hear that some aspect of the National Health Service Corps doesn't include physicians. But --

DR. SHELLY F. GREENFIELD: No, I said, no, it does include physicians, but I wasn't sure as whether there was the new programming for incentives actually included physicians within the NHSC. Because NHSC does include physicians.

MS. KANA ENOMOTO: Right.

DR. SHELLY F. GREENFIELD: But new programs to build the capacity to treat SUD within that, I didn't know that that included the physician part of the workforce. But anyway, that's okay. That's a point of clarification.

MS. KANA ENOMOTO: I'm pretty sure if it's -- it's actually not just SUD. It's MAT. So I'm guessing that that's going to have to include physicians.

DR. SHELLY F. GREENFIELD: I hope so.

MS. KANA ENOMOTO: I don't know if that will be incentives versus loan repayment. But we can, again, HRSA is just right upstairs. We can walk over there and ask them now.

DR. SHELLY F. GREENFIELD: Convenient.

MS. KANA ENOMOTO: Yeah. But --

DR. DAN LUSTIG: On a different side of this thing, is there a reason why certified addiction counselors are never included in any of these programs?

MS. KANA ENOMOTO: I'm sorry. Addiction counselors are part of the MAT.

DR. DAN LUSTIG: Oh, okay. Sorry.

MS. KANA ENOMOTO: Yeah. They, in fact, got a big chunk. So they got \$2 million. There is quite a bit of money going to the addiction counselors.

DR. DAN LUSTIG: Great.

MS. KANA ENOMOTO: Yes.

[Laughter.]

MS. KANA ENOMOTO: From your lips to God's ears. "Well, I shall have," and addiction counselors are in. I just forgot them. They're new. They're new. They came out -- they came in '15. So, yeah.

DR. DAN LUSTIG: Great.

MS. KANA ENOMOTO: Yes. So those programs probably just launched. But they'll be going. So, yes, we're doing master's level addiction counselors as part of Now is the Time.

And then buprenorphine, did you guys talk about buprenorphine?

MS. MARY FLEMING: I don't think so.

MS. KANA ENOMOTO: Oh, look. They perked up.

[Laughter.]

MS. KANA ENOMOTO: So, so we have two things going on in the buprenorphine.

MR. TOM CODERRE: We only have a couple minutes, just so you know.

MS. KANA ENOMOTO: Okay. So buprenorphine, very quickly. This year we are working on regulation -- proposed regulation to increase the cap on buprenorphine so that right now it's limited to 30 and 100, and we're looking to go

somewhat north of that. And working closely with our colleagues at ONDCP, at ASPE, FDA, everywhere else, DEA.

And then in the FY '17 proposal is a pilot proposed for buprenorphine prescribing authority. So that the bupe cap doesn't require funding. It will -- we will do some evaluation of that, but it's not an appropriated program. It is just a change of a rule.

The buprenorphine prescribing authority demo would be expanding prescribing to I think advance practice nurses and physician assistants potentially, and doing that in a demonstration program. This would require a change in the Controlled Substances Act. So we're working with DEA and others on that, but the budget proposal is there. So we're -- this is part of the Secretary's efforts to expand access to medication-assisted treatment.

You know, other things that we're talking about and looking at is how do we -- we have a pilot project with Project ECHO this year. You know, this is whether it's taking the super specialist and having them, you know, do sort of collaborative care with the nonspecialist. So addiction psychiatrist, addiction medicine specialist to non-addiction specialist physicians or the more to sort of the other -- other healthcare disciplines that are able to manage the care in the new prescribing authority demonstration and so forth.

But very exciting work happening in that space as well.

DR. HENDREE JONES: Can you talk about what that demonstration project would look like with the buprenorphine prescribers that are nurse practitioners and PAs?

MS. KANA ENOMOTO: Well, we don't really know. I think it would -- I don't know if it's in States or -- I think it has to be in States that would permit it, and we'll need some statutory language that would allow it and then looking very carefully at things like treatment outcomes. Well, what are the training programs, supervision, diversion risk, and so forth?

So, yeah. So we're excited about both of those opportunities. So, all right. Well, thank you very much.

MS. MARY FLEMING: Thank you, Kana.

MS. KANA ENOMOTO: Appreciate seeing all you guys. Take care. Bye.

MS. MARY FLEMING: And it's time for us to take a break and reconvene at about 3:15 p.m.

[Recessed at 3:03 p.m.]

[Reconvened at 3:21 p.m.]

Agenda Item: Review and Discussion of Joint NAC Questions

MS. MARY FLEMING: Why don't we go ahead and get started? The last hour or so of the meeting, we wanted to go over the plan for tomorrow and talk a little bit about the breakout groups. Having said that, the materials are in your binders. So I'm assuming they are. We had some binder issues.

They're in your binder. So I'm thinking that we could go over them fairly quickly. I would like to spend a little bit of time talking about what you might have an interest in having on the agenda for our next meeting, which I think will be in August. Is it August?

FEMALE SPEAKER: It's like always in August.

MS. MARY FLEMING: Yeah, it's always August. I remembered them always being August. But I don't think we've had them in February before. So I didn't know if maybe we were going to --

MS. SHARON AMATETTI: It's in August because they want -- some of the NACs have to review grants.

MS. MARY FLEMING: Oh, that's right.

MS. SHARON AMATETTI: And they want to have the Joint NAC.

MS. MARY FLEMING: Right. So, so I would like to spend a few minutes talking about that. And then we might be able to adjourn. Is there a particular time that a shuttle is coming for folks or --

MR. JOSH SHAPIRO: I can call him if you think you're going to get let out early, but I can call and tell him to come whenever.

MS. MARY FLEMING: I just want to make sure that folks aren't waiting for a really long time if we end up ending early. So let's see how things go, okay? Thanks, Josh.

MR. JOSH SHAPIRO: Okay. Maybe I'll just call him and tell him to be on the ready.

MS. MARY FLEMING: All right. That sounds good.

Tomorrow, there is a significant amount of time on the Joint NAC agenda for the

members of all the committees to break out into five smaller groups, which will be facilitated by subject matter experts and a representative from the OPPI policy team. And you all will be asked to pick a group to go to.

I think it's going to be, Sharon and I were talking briefly, important for you to sort of to try to I think represent the issues of women as you are involved in these discussions because, you know, obviously the CSAT folks and CSAP and CMHS folks will be there representing the interests of their group. And not that it's a competition, but I also want to make sure that your issues aren't lost in the discussion.

The questions, I went over them last night, are not necessarily tailored to I think easy input by you all, and in terms of, again, having your issues represented. So I think if we could just spend a few minutes talking about the topics. We've spent a fair amount of time talking about one of the topics. So, and -- and then, obviously, tomorrow you all can just decide where you want to go.

The first topic is the development of certified community behavioral health clinics, Section 223. And Cindy will be leading that group with Sarah Steverman, who is working with us, with me on the statewide TA group, along -- and doing a fair amount of work with the financing group.

These are in the first part of your binder. It's Tab 6. It says "breakout groups." Cindy has the same presentation that she had from this morning. I don't know that she's planning on doing that presentation. She may do a shorter version of it.

But on the second page of the briefing document are the questions that the group will be asked to consider. They are not -- they are in many ways consistent with some of the questions and issues that you all raised as a group today, including looking at how States are engaging stakeholders in the process, and I have encouraged them to think about that far more broadly than mental health consumers and their family members.

That we really need to expand that to persons in recovery and their family members and to the provider community, to the healthcare community, to criminal justice. That we really need to have a much broader discussion. I think that serves consumers and families well because they can also begin to see how they can impact some of those other community resources and organizations. But so that the issue of stakeholder engagement is one that they'll be talking about along with ways to continue to engage the other 16 States that at this point would not be selected.

And then I think an area where I would expect you all to have some clear input is about what would an ideal CCBHC look like? What kinds of services? Who would they serve? What would be the differences in an urban versus a rural

setting? I think much of our discussion has focused on more urban or suburban kinds of environments. I think the issues around rural CCBHCs and particularly access to substance abuse treatment is a major issue.

So what would that look like? What would staffing look like? Workforce is just -- and maybe that's a topic we talk about in our -- one of our meetings, if you've not, is sort of workforce development. So what would the ideal workforce look like in those areas?

And I need to correct something that I said, Carole, on the AOT discussion because I was wrong. Because I think I was reading what I wanted to read into it.

DR. CAROLE WARSHAW: I thought that was a great idea. Can we put that in?

MS. MARY FLEMING: It was a great idea. Unfortunately, unfortunately, I didn't write the legislation. So the goal is to improve the availability, accessibility, access to, and participation in assisted outpatient mental health treatment. In terms of one of the four objectives that a State can apply for --

DR. CAROLE WARSHAW: That wasn't in the original legislation. It got added in at some point?

MS. MARY FLEMING: It is in the legislation because I actually didn't believe it was in there either, to be perfectly honest.

DR. CAROLE WARSHAW: Because we looked at the original --

MS. MARY FLEMING: It was in what was passed, though. So, as you know, Peggie was very polite in her way of talking about how the sausage gets made, and I had said to her talk about how sausage gets made. And obviously, what starts out and what ends up in a bill is very, very different. And you all know that, and the compromises that are made along the way and at the last minute.

DR. CAROLE WARSHAW: So I guess a question is, for this, how much -- you know, where is there room for input? And is this -- the input we would be providing, is it around how you select the States? Like what we think, you know, the ideal CCBHCs would look like so that when you're developing your evaluation criteria that that would be part of it? Or is it for the evaluation that gets put in place by SAMHSA to evaluate the demonstration?

So where is the opportunity to actually influence this?

MS. MARY FLEMING: I think the opportunity to influence at this point in time is around how States are selected, understanding that the guidance is already out there. So that can't --

DR. CAROLE WARSHAW: You can't change that.

MS. MARY FLEMING: You cannot change that. So there are a couple places. One is, I think, how States are selected. So how the evaluation criteria are operationalized or fleshed out. So I think that's one area.

I think the evaluation is one. And I would say -- is a second area. And I would say in particular what kinds of measures of effectiveness would you think are helpful? There are 32 quality measures listed in the criteria, which is a lot. There are 11 core measures that CMS requires.

FEMALE SPEAKER: Like HEDIS measures or something?

MS. MARY FLEMING: Yeah, they are NCQF-endorsed measures. There are 11 of them that are not negotiable. CMS requires them. Can't change them.

There are 22, 23 that are measures that SAMHSA has put into the criteria. There is room in the criteria to modify those measures in some way, either take some out, to change them perhaps in some way. There is some -- there is some room around the edges of those.

Then there are measures that the evaluation team will want to use. So to the extent we can begin to identify things that it's important for us to learn from this demonstration and, I might add, things that we could learn in the short term. Because if you think about this, the report on the evaluation is not due to Congress until 2021. I would argue that the decision about the future of this program is going to have been made long before 2021.

So we are really having some discussions about how do we find either some proxy measures of success or some measures that we can begin to impact on and demonstrate movement on more quickly? Some of those are going to be process measures. Just are we serving more people? Do we have more crisis systems? Are we getting more people engaged in treatment?

Many of the measures, if you're familiar with them, that are currently in place are measures that are collected yearly. So between that and the lag in getting data, are we just out of synch with being able to demonstrate the effectiveness of the program? So I think that there is a place for some discussion and impact around that. The question, I think the challenge will be fitting them within the scope of the questions.

DR. CAROLE WARSHAW: Are those measures available?

MS. MARY FLEMING: They are. They're online as part of the criteria. They're Appendix A, I think, of the criteria. I think they're Appendix A. Are they?

FEMALE SPEAKER: Page 63.

MS. MARY FLEMING: Page 63. Some of the measures are not NCQF endorsed, and we actually are developing technical specifications for them. So for those of you who are researchers, I think there are a myriad of data collection issues, let me just say. So I recognize that full well. So I would argue the more we could move toward more standardized, endorsed measures, the better off we'll be. And measures we could collect more frequently than yearly.

One thing that we did not talk about is the evaluation requires the use of comparison sites. We are struggling with that, and we've talked to the grantees, to the States about that. There is really no money for that. There is very little money for the evaluation to begin with, and if you think about having comparison sites, that is a burden on a provider to collect this data, and there is no financial incentive to provide. So I think we're looking at also finding some way through claims data to construct comparison sites in that manner.

So the evaluation, I think, is really important to this, but finding a way to create something meaningful is going to be -- in the short term is going to be, I think, a challenge. So one of the questions is -- Question Number 4 is really around measurement and evaluating the effectiveness of the programs. So I think, you know, Carole, that's really the way, the place where we can have the most impact.

I say "we," I'm talking -- see, I've already identified as part of you. Where --

DR. CAROLE WARSHAW: And there's other opportunities for input if you don't go to that --

MS. MARY FLEMING: Yes. Absolutely. Absolutely. Yeah. We have a portal on the -- on our Web site where you can type in questions, or you can always ask me and I can get them to -- if I can't answer them, we meet weekly to funnel and review all the questions that we get from the field and parse them out to the correct folks.

DR. SHELLY F. GREENFIELD: I just have a question.

MS. MARY FLEMING: Sure.

DR. SHELLY F. GREENFIELD: And maybe this isn't the right moment to ask it. So when the data is -- sorry. Question. When the data for the -- well, either the planning or the demonstration groups happens, will there be a mechanism by which that data, if it's through administrative components, could become available to like a center that's funded to research questions about that?

MS. MARY FLEMING: I don't know the answer to that. I would -- I would say probably not because it will be Medicaid claims data. So CMS will own the data. We won't own it.

DR. SHELLY F. GREENFIELD: Right. Right.

MS. MARY FLEMING: So I think you would have to -- CMS licenses some of their data.

DR. SHELLY F. GREENFIELD: Yeah, yeah. No, no, and --

MS. MARY FLEMING: Yeah.

DR. SHELLY F. GREENFIELD: But as CMS Medicaid data, I'd just -- it's just -- how should I express this? So there are, I'm part of a center that's funded through NIDA that looks at the Minnesota twins data for like substance use disorder care. It's awarded to Harvard and Brandeis. And they often do use Medicaid claims data.

And just, I have just a thought. It's just really more about maximizing and leveraging funding that if you wanted to potentially have some outcomes measures looked at, that's a center. It's completing Year 1. There are 5 years of it. It's a P30. And it's just a thought about something that's got some funding over here that could be potentially leveraged.

That's what my thought it.

MS. MARY FLEMING: Mm-hmm, okay.

DR. SHELLY F. GREENFIELD: So if there's an opportunity in that direction, I can, you know, facilitate a conversation or something like that.

MS. MARY FLEMING: All right. Let me, if I could contact you offline, that would be great. Thank you.

DR. SHELLY F. GREENFIELD: Yeah, yeah. Absolutely. Just a thought. I was just listening. It was just a thought.

MS. SHARON AMATETTI: How are the sessions going to work tomorrow? They self-identify which ones --

MS. MARY FLEMING: Yes.

MS. SHARON AMATETTI: And are they only able to go to one or two apiece? I can't remember --- I'm just asking about the process for tomorrow so that the members know where they want to spend their time.

DR. HENDREE JONES: It looked like it was one breakout.

MS. SHARON AMATETTI: It was one? Okay.

DR. HENDREE JONES: Because it's 1:35 p.m. to 2:45 p.m. So I don't think you could participate in two, sadly.

MS. SHARON AMATETTI: Pick your battle.

DR. HENDREE JONES: I'm interested in several.

MS. SHARON AMATETTI: Okay, thank you.

MS. MARY FLEMING: So any other thoughts about the CCBHC discussion?

[No response.]

MS. MARY FLEMING: Okay. The second group will be on efforts to address early serious mental illness. And this is really focusing -- it's trying to help inform our use of the what's now 10 percent set-aside in the mental health block grant for early episode or first episode psychosis. If you recall, in the '17 budget, we're looking at moving even further upstream with some set-aside around children or adolescents at risk for first episode psychosis.

But this is focused more on our current efforts with the block grant, and it's, as you all know, there is frequently a delay between the onset of symptoms and people seeking treatment that is not insignificant. And one of the areas that the group will be talking about is what you think some of the barriers might be to folks seeking treatment at an earlier point in their experience, looking at what best practices you've seen in your communities.

I think and you sort of alluded to this in your own work, Shelly, the idea about implementation of evidence-based practices and whether you cut corners or not, how you -- in my own experience, people will say, you know, I'd have providers say to me, "I'm doing an evidence-based practice," and you try to do fidelity to it, and it'd be like, "No, you're not." And they say, "Well, we've adopted it to our group."

And best I can tell, research suggests that about 80 percent of your outcome is accounted for by adherence to the model, and the other 20 percent is sort of by the quality of the relationship and care. So I think there is some discussion -- we'd like to have some discussion about experience in implementing evidence-based practices and what has happened in attempts to modify that.

I also think we sometimes don't take into account the cost of implementing an

evidence-based practice. It's not cheap to do. And so that will be part of it. The issue related is of mission creep. You know, we've all seen that. You sort of have a good program that works for a population. Will it necessarily work for another population? How do you -- does that begin?

So, so what's the kind of tradeoffs? Do we keep focused on a narrow set of individuals with this funding? Do you try to expand it a little bit? I don't know.

And then the -- the issue, I think, of sort of having a sort of Cadillac kind of program, a really high-level program. How do you target that program when you can't provide it to everybody? What are some of the decisions around if you implement the RAISE program, you can't provide RAISE to every adolescent or young adult who may be in need of it. How do you sort of message that? What's the rationale behind that kind of decision-making? I find these questions to be very tough, having been in places to have to make these kinds of decisions.

So those would be the types of discussions that would occur. And I think, you know, obviously, you've -- you have some thoughts based on the populations that you serve and are interested in on how you might make some decisions around kids at particular risk, young women at particular risk. How do you target them and find them? Any thoughts about that?

DR. SHELLY F. GREENFIELD: Are you asking for thoughts now?

MS. MARY FLEMING: Well, I don't know. If you've got any.

DR. SHELLY F. GREENFIELD: How you find?

MS. MARY FLEMING: I mean, are these questions that would resonate with you to participate in discussion tomorrow, sort of?

DR. SHELLY F. GREENFIELD: Oh, sure. Of course. Absolutely. Absolutely.

MS. MARY FLEMING: But we don't have to have the discussion today. I just want to make sure everybody is finding a home tomorrow. So --

DR. SHELLY F. GREENFIELD: This is you're talking about -- this is in terms of early serious mental illness. You know, if you're talking about and one thing just about women is, you know, if you're talking about identification, there is different age of onset. So that if you're targeting adolescents, you are maybe missing young women who are having the first set of symptoms. So there is the population prevalence is mostly equivalent, but the age of onset is different, with young women having a slightly older age of onset.

So in other words, just in terms of looking at populations and just bringing the woman focus to this, that might be something to consider, you know, which is

that you are probably looking at slightly different groups. And I think often because we tend to think about it as more of the 18- to 22-year-old population, you're going to miss, I think, the women who are having onset where it's more 22 to 30.

And people aren't really going to think about it. So you could see that as an opportunity to miss early intervention, and now we know that early intervention in this group actually has a lot to do with how people will fare over the lifetime. And if the intervention happens early, there is a much better prognosis. So you could imagine this becoming a disparity issue by gender.

DR. CAROLE WARSHAW: Another thing, I'm just thinking about all the kind of -- I don't know what's involved in the first break kind of programs, but if it includes all the other kinds of issues that may come up in kids' lives who -- or young people's lives that may kind of help precipitate more people becoming more symptomatic, you know, what actually supports their being healthy and connected and what kind of things are likely to -- layers of traumatic and poverty-related experiences.

So I don't know how much of that kind of stuff is embedded in those programs, or it's more narrowly focused so they're not -- maybe should be.

MS. MARY FLEMING: The programs that I'm familiar with tend to be sort of almost in a sort of community treatment model program, where they're fairly intensive. And they do --

DR. CAROLE WARSHAW: But do they deal with those kind of social issues as well?

MS. MARY FLEMING: Yes, I think the good ones do deal with those social issues.

DR. CAROLE WARSHAW: Oh, good. Okay.

MS. MARY FLEMING: Yeah, yeah.

DR. SHELLY F. GREENFIELD: It's not funded in this way, but we have a first episode program. And they're using -- they're intervening in all sorts of ways and utilizing cognitive remediation and a whole host of things. Oh, I'm sorry. We do have a program like this, and yes, they do try to integrate a lot of different -- including cognitive remediation and a whole host of other things. But I can't speak to all the CSCs. I don't know, but --

MS. MARY FLEMING: And one thing I have to admit I'm not clear about, and I will try to get some clarification tonight is how much of a presentation there will be to kind of set the stage because I think we had a great presentation today on

223, which really set the stage for that discussion. I don't know to what extent that will be the case for any of these other topics.

DR. CAROLE WARSHAW: The other thing is there's a lot of work on gender-responsive substance abuse treatment for, you know, young women and girls and adult women, and there's not much on the mental health side specifically. So I don't know whether there's a place for that in these programs and whether that exists. Is there any model for it, or it's just people do it because they do it?

MS. MARY FLEMING: I'm not as familiar with that. So I mean, I think that's a great question.

DR. CAROLE WARSHAW: I just don't know, but --

MS. MARY FLEMING: The third group is on mental health parity and addiction equity. The briefing document provides a bit of a background about parity and the protections offered under it and the exceptions to it. The discussion will really -- Chris has wanted to focus on how have you seen it play out professionally in your programs, how you've seen it play out perhaps personally or in your community settings.

And then I think one of the things that we're really trying to sort of determine right now is what should SAMHSA's role be in the issue of parity? So I think that will be a focus of the discussion. As you know, it's -- just States have particular responsibilities. Labor does, and CMS and Treasury. And SAMHSA is trying to figure out sort of what is its space in that, and I bet you got a thought.

DR. DAN LUSTIG: The last thought. You know, what I'm seeing with a lot of the managed care, as it relates to parity, is the lens that everyone is looking through is medical necessity. So, as an example, to get a woman with a 22-year history of opiate addiction into medical detox is almost impossible because many people believe that opioid withdrawal is not life threatening so, therefore, they don't need to have the type of detox.

So that has been a huge issue even when I get on the phone to talk to managed care providers. And so, you know, again, not a supervisory role, but an education role of this is going to be critical because I can honestly see how a lot of the managed care providers and insurance providers are getting around parity, and they're getting around it very well. I mean, when someone says the word "medical necessity," you're done.

MS. MARY FLEMING: Just on a personal note, I was trying to get my son into detox, and I never have trouble getting him into residential services in detox. But he was going only to detox. It was very interesting to hear the staff person coach him on what to say when he talked to the utilization review folks at the insurance company. It was -- it was very interesting for him.

And essentially they told him to bump up his -- the amount he was using. It was -
- it was just -- you know, and I'm sort of sitting there thinking, you know, okay,
he's an adult. But it sort of, I think, speaks to that. Not a woman, but still trying
to get him the level of care that everybody thought he needed. So --

DR. SHELLY F. GREENFIELD: This is always -- this is always the incredibly
difficult challenge that, you know, for substance use disorder care that everybody
faces. And Massachusetts just implemented legislation to basically say that
there now will be no need for any prior authorization for substance use disorder
services, and we are -- it just started in January. So we are just --

DR. DAN LUSTIG: Does that include -- because I've seen that happening across
many States, actually. But is that including medical detox?

DR. SHELLY F. GREENFIELD: So we'll see how it goes. This has been
because of everything you know about, because of this intense -- because we
have people dying like every day of the week of overdoses and in every
community across the entire State. This is one response, and we'll see how it
goes.

And to your point, though, we don't know how there will be other ways that
insurers will try to get around this. But for right now, this just got started. So we
haven't had a chance to see how it goes. But it's really to speak to exactly what
you're saying. It's terrible. Right now, if the doctor and the patient think this is
necessary, it does not require prior authorization for up to a certain number of
days.

MS. MARY FLEMING: That's great.

DR. SHELLY F. GREENFIELD: We'll see.

DR. DAN LUSTIG: So the doctor has to be involved? So the client can't walk --

DR. SHELLY F. GREENFIELD: Clinician, clinician, clinician.

DR. DAN LUSTIG: Great.

DR. SHELLY F. GREENFIELD: We'll see. It's just started. Just started.

DR. DAN LUSTIG: There's hope, right?

DR. SHELLY F. GREENFIELD: Right, we'll see.

DR. DAN LUSTIG: Glass is half full.

MS. MARY FLEMING: Now if we could only get it in the PPS. So that will be one of the other, the third group. The fourth group will be on opioid, the national opioid crisis, and we've actually -- there are a lot of background materials in here, which you can peruse at your pleasure.

Focusing -- the questions that the group will be looking at is how does CSAP, can CSAP use its new funding to expand availability of naloxone? How to integrate peer support recovery into MAT, and how do we measure our success in that area? How can we improve access to MAT within substance use disorder treatment systems? And I think you talked about this with your human trafficking program. I think it's probably more -- it's pervasive across sort of treatment is how do we engage people in treatment?

They frame the question as how do you link people to treatment after an overdose? I think the real issue is how do you engage people in treatment and keep them engaged for a substantial period of time? And I know we've begun to have more and more discussion --

DR. DAN LUSTIG: Just briefly, you know, many States have implemented a recovery --

MS. SHARON AMATETTI: So now we know the issue with this room, as we're learning.

DR. DAN LUSTIG: Many States have implemented recovery coaching, and it is an EBP. And many clients that have overdose that are linked to recovery coaching have seen decreases in future overdoses. I'm not saying it's an answer necessarily, but it certainly is an in-road that I've seen a lot of good outcomes from.

MS. MARY FLEMING: And recovery coaching is different than recovery peer support.

DR. DAN LUSTIG: Right.

DR. SHELLY F. GREENFIELD: Yes.

MS. MARY FLEMING: Okay.

DR. DAN LUSTIG: Even though I am a fan of both.

MS. MARY FLEMING: Right. Okay.

DR. HENDREE JONES: The issue with the naloxone piece, which I hope comes up tomorrow, is pharmacies. Because you can give all the money in the world you want to expand it. But if you don't have pharmacies that are actually going to

carry it, and that has been a huge issue. So we need to have some kind of partnership, linking discussions, education with and pharmacies need to be able to have it on hand.

MS. SARAH NERAD: Now is this decided at the State level? Because I know like CVS just started carrying it, and I think quite a few States, Walgreens? So I don't know if it's like States, whether that chain of pharmacies or if it's the whole company. But quite a few, like I know Walgreens. At least in Ohio, I've seen Walgreens, CVS, and local ones, Kroger.

DR. HENDREE JONES: Yeah, State -- I would -- we need to make sure that it's happening everywhere. Hopefully, as a company, they have decided that.

MS. SARAH NERAD: Yeah.

DR. HENDREE JONES: But my fear is a lot of them are independently owned and operated, and so it's -- yeah. So it's just I would hate that's like a --

MS. MARY FLEMING: So I guess a question is if the corporate policy allows it, do the stores actually have it?

DR. HENDREE JONES: Right.

MS. MARY FLEMING: And do people know how to get it?

DR. HENDREE JONES: Exactly.

MS. MARY FLEMING: So there's sort of down the chain.

MS. SARAH NERAD: And that you need to be able to get it without a prescription.

MS. MARY FLEMING: Yes.

DR. HENDREE JONES: Yeah. And without ramifications, repercussions, yeah. Pharmacy giving you the dirty look.

MS. MARY FLEMING: Right.

DR. SHELLY F. GREENFIELD: Just one comment. Unfortunately, I'm not going to be able to be at this breakout session, and which I regret. Just two things, like first of all, I hadn't seen this medication-assisted recovery and medication-assisted peer recovery support services report, which is really interesting because it actually addresses linking peer recovery support to MAT, which is really fantastic because it's like building the bridge to one of the barriers to actually having this take place. And you know, recovery [inaudible].

So that, I just -- I mean, just in terms of dissemination, that just seems like a great thing to disseminate.

DR. DAN LUSTIG: And do you know what the most powerful thing that's come out of this is because so many patients, when they go to support groups, if you're on MAT, you're not in recovery.

DR. SHELLY F. GREENFIELD: That's right. This is one of the biggest --

DR. DAN LUSTIG: And so having a peer has really empowered them to maintain the medications.

DR. SHELLY F. GREENFIELD: Yeah, this is really an important thing, just in terms of changing the culture within.

DR. DAN LUSTIG: Absolutely.

DR. SHELLY F. GREENFIELD: The other thing I wanted to mention, so it's so interesting that you have this back-to-back with the SAMHSA opioid overdose prevention toolkit because one of the things that I think is not that well perceived by both the public and policymakers and all sorts of folks who are involved in trying to do the right thing is that providing opioid overdose prevention or treatment in response to an overdose, that is like, you know, giving people, you know, cardiac resuscitation when they're in the midst of having a cardiac arrhythmia. But then we don't send them home to their house. We usually put them in an ambulance, and they go to a hospital.

And you know, it's a lot of people equate this with having implemented treatment for substance use disorders, and in people's minds, this is coming up now. So if you're making naloxone available --

DR. CAROLE WARSHAW: You mean like an epi pen for a bee sting?

DR. SHELLY F. GREENFIELD: Or literally like having a defibrillator. So you have a defibrillator. You're having cardiac arrhythmia. You defibrillate, and then bye, you know? And that sounds so ludicrous when you say it in that way, but actually it's in the minds of many this is providing care. And this is an emergency service that needs to be available.

But the fact that you've got these two things linked in this binder is like a great thing because what you really want is just figure out how to really link them.

DR. DAN LUSTIG: So much of the policy is written on getting the medication out there, and very little policy is on linking the person to treatment. And that's -- and there's been this -- an important rush to get it to -- into people's hands, but there

is very little policy on making sure this person is linked to treatment.

DR. SHELLY F. GREENFIELD: Yeah. So that's just it's really -- so it's just one of those other things. It's so hard to believe that that would be the case. But people wouldn't immediately perceive, oh, this is an emergency procedure to save a life right in the moment when somebody would otherwise die. But once you've done that, you know, that you need to move them into care, you know?

And so, anyway, I just wanted to mention that because it's sort of like a beautiful thing that they're back-to-back in the binder, you know? But the actual linkages are weak at best. And I think there still is problems getting naloxone out there to people. I think there's a lot of problems.

MS. SARAH NERAD: And treatment centers, when folks are getting ready to leave, like doing overdose prevention with them, giving them naloxone, I don't know that anywhere in Ohio is doing that. But that's such a time when folks tend to relapse. Well, if they relapse, they're more likely to be fatal. So I don't know if there's been any discussion about like should treatment centers do more of that? They're in the family groups because we just see that all the time.

DR. SHELLY F. GREENFIELD: It's high risk.

MS. SARAH NERAD: And we have like a captive audience. So it's really hard to like get naloxone to folks that aren't currently utilizing a service, but it is easy to give it to folks in drug court, folks when they show up in the emergency room, folks in treatment, and their loved ones. So --

MS. KAREN MOONEY: We actually have some jails that are distributing it at discharge.

MS. SARAH NERAD: That's awesome. Yeah. I want more.

MS. MARY FLEMING: My son lives in Sober Living, and they have it --

MS. SARAH NERAD: There?

MS. MARY FLEMING: They have it there.

MS. SARAH NERAD: Good. I know a couple college campuses are starting to do it. Ohio State is working on it. I know there's a couple others in Ohio and then some States, a few other States that have schools that want it. But I think that's awesome.

MS. SHARON AMATETTI: I would also suggest that whoever goes to this breakout that you raise some of the issues for women in particular to the opioid disorders. So Dr. Campopiano, who will be leading this discussion, is -- she's

wonderful and very aware of those issues. But I think it would be good to get them on the record. A feeling.

MS. MARY FLEMING: Yeah. Will you be there, Sharon?

MS. SHARON AMATETTI: I hope so.

DR. HENDREE JONES: It is interesting, though. I mean, we went through this like last little piece of the opioid overdose. It says recovering from opioid overdose. Resources for overdose providers and family members. Finding a network of support. Nowhere does it say how about let's think about getting into treatment.

DR. SHELLY F. GREENFIELD: Or medication-assisted treatment.

DR. HENDREE JONES: Yeah.

DR. SHELLY F. GREENFIELD: That's what I mean. It doesn't say medication-assisted treatment for opioids.

DR. HENDREE JONES: Wow. Oh, they do have a buprenorphine treatment physician locator in here and a resource. Good luck. It's interesting. Okay.

MS. MARY FLEMING: Great points.

DR. SHELLY F. GREENFIELD: You know, one issue about disseminating naloxone also that we found is that, you know, to get it, you often have to have a prescription for a patient. And in order to get it reimbursed, it's tied to that person's reimbursement. But if you wanted to get it into programs, you know, how do you do that?

So we've had some issues about how do you get naloxone into the residential treatment programs or the day treatment programs because so it's like an epi pen, you know? So you would want an epi pen there just in case any person there has an allergic reaction, you can use the epi pen. But you don't have it all necessarily prescribed for a specific person. You could --

MS. SHARON AMATETTI: So it's a supply.

DR. SHELLY F. GREENFIELD: It's a supply. That's what I'm trying to say. Thank you. So we've had a lot of work-arounds to get it into our program, and I can't tell you all the nature of the work-arounds, but someone on our -- one of our physicians has like spent a considerable amount of time doing work-arounds to make sure that that's there.

So that's just like another thing. It's like it should be just like what you said. It's a

supply. It's like having a defibrillator, having an epi pen. You have your naloxone. People are trained to use it. So it's there. But that's been an issue. Anyway.

MS. MARY FLEMING: Okay.

DR. CAROLE WARSHAW: Another -- in terms of gender differences around the advantage of buprenorphine versus methadone in women's lives? I know you said the PPW and that you can use naloxone in people who are pregnant. Yeah. So what about just the use of those in women's lives and, you know, having to go every day versus being able to take it yourself?

DR. HENDREE JONES: There have been a couple of papers in the literature. Schott and Phillips did the first one in like '98. We did a couple of them. There's nothing -- there's nothing really. It doesn't matter.

DR. SHELLY F. GREENFIELD: Well, not so far -- there's no -- there haven't been differences by gender --

DR. HENDREE JONES: Right.

DR. SHELLY F. GREENFIELD: -- in the outcomes for either of those in the large studies unless, you know, once other things have been controlled for.

MS. SARAH NERAD: It's not a gender thing?

DR. HENDREE JONES: No. Sarah is asking about employment. I mean, it's still -- if you have to go a methadone clinic every day, that can be a barrier to employment. But that's not divided by gender at all. I mean -- well, it can be.

MS. SARAH NERAD: I am just thinking about broadly, like just because --

DR. HENDREE JONES: It can be.

MS. SARAH NERAD: -- gender discrimination still does exist, and if a woman was like, "Oh, I have to be late every day, you know," if they faced any more?

DR. HENDREE JONES: Actually, so you're correct. I mean, you're very correct about barriers to care. That is correct, and that barriers to care often segregate by gender. I think the difference is once in the treatment by the studies, they are equally effective. But the barriers to getting into the treatment actually much vary by gender. And employment is an interesting one because it can be a barrier.

MS. SARAH NERAD: So I have kids, and I can't come every morning.

DR. HENDREE JONES: Yeah, absolutely. But that's not -- but it's not specific to

methadone or buprenorphine, that's just a general treatment barrier. That was my point.

DR. SHELLY F. GREENFIELD: And sometimes, actually, the employment, there was one study that we looked at for emergency room intervention for people. The employment became the barrier for men who were more fully employed than the women who were being intervened on, and they were the ones endorsing employment and not being able to access care early in the morning or in the evening as their major barrier, which was kind of interesting.

And the childcare-related stuff was being endorsed. It's not a big surprise. But you know, these things, because of the gendered nature of some of these demographics, actually can lead to barriers to getting into the treatment, yeah.

DR. CAROLE WARSHAW: And I wondered also about like if they have to methadone -- if you have to go to get your methadone every day, it's easier to be stalked because you're going to some place all the time. So someone can track where you are. But if you're getting something that you can take it home, it's easier for someone else to access your meds or control them. So I just wondered if that had come up in any of the work?

DR. HENDREE JONES: I don't think -- I mean, it's harder to over -- just in terms of like access, like you think of like children getting, having access to medication? Is that what you mean?

DR. CAROLE WARSHAW: No, I meant like an abusive partner.

DR. HENDREE JONES: Oh, oh, absolutely that comes up all the time. Oh, yeah. I can't tell you how many women we have --

DR. CAROLE WARSHAW: And so what's safer for people?

DR. HENDREE JONES: -- in the clinic and especially with women who are pregnant who are only prescribed subutex because it has a greater abuse liability than suboxone does. And so, yes, we have women that have had their subutex taken by their partners and sold and used.

DR. CAROLE WARSHAW: Okay.

DR. HENDREE JONES: And that's a gender thing.

MS. MARY FLEMING: Safe trips back. Safe trip back. There's a tornado warning. I hope your flight goes off.

[Background conversation.]

DR. SHELLY F. GREENFIELD: Just while you're talking about the MAT, it's just worth saying that, you know, there is a third medication-assisted treatment, which is naltrexone, depot naltrexone. And we just need to add it in there because access to that -- that actually can be a very important third medication for a lot of people, and access to that is actually hard for people.

And we're, you know, finding out more and more about like for whom that might work best. And it's just nice to have a third thing in the armamentarium for people and just worth thinking --

MS. MARY FLEMING: And we are -- we try to make sure that we mention that in terms of our including it in MAT. I know we typically -- we easily fall into the buprenorphine discussion, but we really --

DR. SHELLY F. GREENFIELD: Yeah. Yeah, I know you guys do. I just wanted to --

MS. MARY FLEMING: You know, it's important, though.

DR. SHELLY F. GREENFIELD: Yeah, and also I think we don't know fully about the gender-related issues with that either because that's just being studied now.

MS. MARY FLEMING: The fifth group is -- is on integrating social determinants of health into behavioral healthcare. And Larke Huang will be facilitating that group, and I think it's fairly self-explanatory.

We've done some work in terms of looking at more of an ecological model of behavioral health and in viewing behavioral health from a public health perspective, and I think we're trying to figure out what SAMHSA's role in supporting the delivery and financing models that sort of take into account some of those social determinants. And what are the implications for workforce in terms of looking at that.

So we know we have a responsibility around housing and employment and safety, crime. So where can SAMHSA carve out a role in terms of those discussions and activities?

DR. CAROLE WARSHAW: Can you say more? Because the questions there were a little thinner. It seems more formative stages. I'm just trying to think of like, I mean, workforce development isn't going to help housing and employment and all that kind of stuff. So how are you thinking about it so far in terms of SAMHSA's role --

MS. MARY FLEMING: Well, let me --

DR. CAROLE WARSHAW: Or what's already happening with that that SAMHSA

could kind of engage?

MS. MARY FLEMING: I would hate to speak for Larke. So --

DR. CAROLE WARSHAW: I'm just thinking of priming, you know, like what kinds of things are in the realm of what SAMHSA could do?

MS. MARY FLEMING: But in terms of when I did a little bit of work when we were sort of forming this in my prior role, and we were really trying to think about a way in which behavioral health was, how can I put it, was sort of a part of the fabric of all parts of the community. So it didn't matter where you showed up. If you had a mental health or substance abuse issue, you could expect to get some help for it, support to move into a recovery path that people were aware of the issue and the sort of issue of stigma was not so pervasive.

So public housing, you could -- you could, in fact, get safe, affordable housing. The fact that you had a substance abuse problem or an issue would not immediately negate your ability to have safe housing. If you went to your -- you know, how do you integrate into healthcare? It takes sort of the idea of having a healthy community means you have to have a behavioral healthy community.

So how do your school systems address issues of behavioral health? From a systemic point of view, just not from SAMHSA or somebody putting a grant program in there, but how do you create a culture or a community that looks at behavioral health? So I think Larke will approach it from issues of disparity and issues of trauma, and how do you address those in various ways?

Having said that, I have not talked to Larke since she has really begun working on sort of fleshing this out. So I know that was sort of our early thinking was sort of how do you take behavioral health and sort of permeate the idea that behavioral health is important to everybody?

DR. CAROLE WARSHAW: Like the public mental health that actually addresses the public mental health or behavioral health --

[Crosstalk.]

MS. MARY FLEMING: It's a public health issue, and how do you get upstream in terms of early identification, prevention, that sort of thing? But like I said, I've not spoken, quite frankly, with Larke about it very recently. I actually didn't know until last night it was the fifth question. So --

DR. SHELLY F. GREENFIELD: Well, it's just -- it is interesting just because a lot of times when the social determinants of health discussions happen in the public health arena, most of it is going toward other medical conditions.

MS. MARY FLEMING: Right.

DR. SHELLY F. GREENFIELD: And it's just a typical thing for mental health conditions, including substance use disorders, to be kind of left on the side there, as if -- as if the social determinants of health don't have the arguably maybe the biggest impact on mental health. It's just that as the public health community like embraces that concept and thinking about, you know, obesity and diabetes and cardiac and all the rest of it, it's just sort of, you know?

So it is kind of an important discussion just from a policy, public awareness, you know, research dollars going toward all of the rest of it because it's, you know, when you think about it, it should be like, you know, if you start to rank the global burden, and then you keep looking, depression is like -- you know, depression and violence, those things are like on the way top of the global burden. But they kind of fall off when people get into this discussion. So it seems like an important thing.

MS. MARY FLEMING: Anything else? If you've got any thoughts about the next meeting of the group and what you might like to talk about in August, whenever that --

DR. SHELLY F. GREENFIELD: Do we have the dates already?

MS. MARY FLEMING: You know, I don't.

MS. SHARON AMATETTI: Not yet.

DR. SHELLY F. GREENFIELD: That's okay.

MS. MARY FLEMING: But we will, I'm sure, get one soon. Any thoughts? Any thoughts?

MS. SHARON AMATETTI: We'll email them.

MS. MARY FLEMING: We'll email them, yes. We will.

DR. HENDREE JONES: And something might come out from tomorrow, too.

MS. MARY FLEMING: Sure.

DR. HENDREE JONES: It might not, I don't know.

MS. SHARON AMATETTI: When you think back on today's meeting, maybe that would help us --

DR. HENDREE JONES: I really liked the presentation that you guys gave. I

really loved that. Sorry.

MS. MARY FLEMING: Thank you for bringing that up because I did make a note that we should have -- it would have been nice to have a longer period of time for the presentations and discussions. So I don't know if we want to revisit any of those. It felt like we were just getting into some of the discussion when we had to stop. So I think -- I think whatever we end up talking about, I really would like to maybe have one less topic and a longer period of time -- pardon me?

DR. CAROLE WARSHAW: Rushing through is different than having a real discussion.

MS. MARY FLEMING: Yes, right.

DR. CAROLE WARSHAW: And some of it is actually doing more in advance to think through. I mean, if there's real questions that we want to think through and come up with something, then we should actually think about that in advance and have some conversation. I know you're limited in your structure of how you can do things.

MS. SHARON AMATETTI: I'd almost like to have longer time for each of you to talk about things that are on your mind, you know, in the beginning, more than just where you work and who you are. But really things that you're thinking about and seeing that you want to raise up to us.

DR. SHELLY F. GREENFIELD: I would just say, I mean, just in terms of future discussions, whether it's August or another time. You know, as I mentioned at the beginning of the day, one of the things that we're really grappling with just in our microenvironment at hospitals, as I said, in the Division of Women's Mental Health, is how you, you know, try to provide services for women that are really comprehensive that address all of the actual issues and conditions that women present with, as opposed to isolating one primary problem.

And my sense is that the way in which -- that there are a lot of barriers to doing that, and what it does is it -- it forces onto women the need to represent themselves only in this one arena, and the rest of what they are managing is like not addressed, necessarily. I mean, because what we're seeing is we have -- we have very super specialized programs. We have like eating disorders programs. We have trauma programs. We have deep borderline personality disorder programs. But the patients actually are the same people. And our substance use disorder.

And the women themselves are forced into getting their care here and then for their eating issue and then for their PTSD and then over here for their depression. And so we've been trying to figure out how you come up with sort of best practices around helping to do what you can do, you know, that is more

comprehensive for the individual.

Because women really do have a very high prevalence of co-occurring conditions. I think it's a very important women's mental health issue. So I just -- it's just one, you know, I would -- and I'm not sure what I would call it exactly. Because I think when you call it comorbidity, it doesn't really hit at what --

DR. HENDREE JONES: It's like whole person care. It's whole person --

DR. DAN LUSTIG: I'm just wondering, though, if maybe what we should -- a goal of ours should be to recommend defining some of this based on gender.

DR. SHELLY F. GREENFIELD: Yeah, yeah.

DR. DAN LUSTIG: Defining integrated care, what does that mean?

DR. SHELLY F. GREENFIELD: Yeah, yeah.

DR. DAN LUSTIG: So that it gives programs something to work towards.

DR. SHELLY F. GREENFIELD: Another way I've sometimes thought about it and we've talked about it locally is like talking about syndemic illness.

DR. CAROLE WARSHAW: What is that?

DR. SHELLY F. GREENFIELD: Syndemic, you know, which is just you have like a syndemic disease, you know, or syndemic conditions for women. These things all go together, and you know --

DR. CAROLE WARSHAW: And they amplify each other.

DR. SHELLY F. GREENFIELD: And they amplify each other. And you know, the biology of it all is such that, in fact, they are linked. And if you treat a woman's bulimia, and she also has co-occurring alcohol dependence, and you don't bother with the alcohol dependence, she will get better from her bulimia and go out and have terrible problems with her drinking and on and on. You can just keep on going with that.

So, anyway, it's really an important problem for women's mental health, and it's really not discussed. And somebody at our hospital, who's more tied in with sort of the funding mechanisms sort of told me that, you know, when in terms of managing finances when care was -- you need to specify the primary problem to be focused on for reimbursement, it actually began to drop out the incentives to recognize the other co-occurring conditions and actually has forced a change over this last, you know, 15 years toward actually only defining the primary problem and all these other things, you know, dropping out of the comprehensive

care management. So I do think it's really a women's mental health problem. It's like a big problem.

DR. DAN LUSTIG: You know, one of the things that we did in Illinois is the Department of Human Services has an advisory --

FEMALE SPEAKER: There's a problem because the rain is starting now behind the air conditioner.

[Crosstalk.]

DR. DAN LUSTIG: No, it's me not remembering. I was dropping my head.

FEMALE SPEAKER: At the end of the day, you're all sitting there.

MS. MARY FLEMING: We're going to put you in the middle the next time.

DR. DAN LUSTIG: One of the things the State did is under human services is we have an advisory council that's actually part of a legislative. Under that advisory council is a women's committee that's legislative that our goal, each and every year, is to provide a report to the State on the gaps in services and what services should be provided and how it should be integrated.

We have to be listened to because we are a legislative body, unlike an advisory body. And it really has helped to separate women's issues from the general whole of everything in a very, very nice way.

DR. HENDREE JONES: Yeah. So in some ways, it would be nice to sort of, oh, think about products and what products come out of committees, right? To have like sort of best practices, and I bet like the people that are around this table, we could come up with a decent one-page list of here are the issues. Here are the gaps.

DR. DAN LUSTIG: I'll share the white paper we did. I can email it to someone, and you could see the white paper.

DR. SHELLY F. GREENFIELD: This is what we're doing just within our division is coming, trying to do that, and I'd love to see the white paper because it's exactly what we're doing.

DR. CAROLE WARSHAW: I mean, that would be great to come out of here --

DR. SHELLY F. GREENFIELD: Yeah.

DR. CAROLE WARSHAW: I mean, I think we'd all feel good being able to actually --

DR. HENDREE JONES: Could you share that paper?

DR. DAN LUSTIG: Oh, yes. I'll send it to you.

DR. SHELLY F. GREENFIELD: And you know, when you're thinking about best practices and women, you know, the population of women that we are specifically talking about are women who are most at risk for nicotine dependence and tobacco use. And the now risk of dying in the United States from tobacco-related causes is equivalent now in women as it is to men, and that gap has closed completely over the last, whatever it is, decade or so.

And that, you know, 50th anniversary of the Surgeon General's report really focuses on women. And our women, the ones with co-occurring, you know, substance use and mental health disorders, the most likely thing they'll die of is tobacco-related disease. And we don't talk about this like we should adequately.

DR. CAROLE WARSHAW: But when you look at the childhood adversity and inflammatory conditions and immune conditions and the links with depression, I mean, it's all of those kind of connections and how do we --

[Crosstalk.]

DR. SHELLY F. GREENFIELD: But I like the best -- like sort of just -- I like something like that --

DR. HENDREE JONES: Yeah, just sort of like -- like a one-pager of like, boom, you know?

DR. SHELLY F. GREENFIELD: It might have to be one and --

DR. HENDREE JONES: All right. We'll have two pages. One page is like I wanted to give you best practices, then another page is, hey, whatever, or tiny font. Tiny font, one page.

DR. SHELLY F. GREENFIELD: We all know what she means.

[Laughter.]

DR. SHELLY F. GREENFIELD: Translate that into the minutes. So I think that would be really awesome. I mean, because it's a big problem. So --

MS. MARY FLEMING: Anything else? Any final comments?

[No response.]

MS. SHARON AMATETTI: Are there any people on the phone?

Agenda Item: Public Comment

MS. MARY FLEMING: Oh, yes. People on the phone, public comment. Sorry. Public comment and final comments.

DR. SHELLY F. GREENFIELD: Josh, are there any -- is there anyone on the phone, Josh?

MR. JOSH SHAPIRO: There are about seven people left.

DR. SHELLY F. GREENFIELD: How many people were on the phone?

MR. JOSH SHAPIRO: You had about 20 throughout the day.

MS. SHARON AMATETTI: Plus I got some emails about --

MR. JOSH SHAPIRO: Eighteen on the webinar.

MS. SHARON AMATETTI: I got emails about how much they enjoyed Carole and Shelly's presentation. Yeah.

MR. JOSH SHAPIRO: Sima, are you there?

OPERATOR: Actually, I took over for Sima. Would you like me to open the lines up? We just have a few participants. I can just open their lines.

MR. JOSH SHAPIRO: Sure. If you could just ask them if there is any public comment.

OPERATOR: Yeah, definitely.

MR. JOSH SHAPIRO: Thank you.

OPERATOR: Actually, we'll just go ahead and do just the queue to avoid that echo. Participants can actually hit *1 on their phones if they would like to make a comment or ask a question.

[No response.]

MS. MARY FLEMING: No comments or questions.

[Background conversation.]

OPERATOR: Actually, it does look like we have one queued up here from Deb
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Warner. Go ahead, Deb. Your line is open.

DR. DEB WARNER: [on telephone] Hi, everyone. This is Deb Warner. I just wanted to say hello. I don't have a specific comment for the record. It just was a great conversation. I really enjoyed listening throughout the day.

MS. MARY FLEMING: Hi, Deb.

DR. DEB WARNER: You guys have been doing great work. I'll let you tend to the [inaudible].

MS. MARY FLEMING: Thank you for joining.

OPERATOR: And I have got no other questions or comments.

Agenda Item: Closing Remarks/Adjourn

MS. MARY FLEMING: Thank you very much.

Okay. Well, thank you all for the day. I appreciate your participation and energy, and we'll see you tomorrow.

[Whereupon, at 4:24 p.m., the meeting was adjourned.]